PEPPER COMMISSION REPORT
(Part 2)

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BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

RECOMMENDATIONS OF THE PEPPER COMMISSION REGARDING A PUBLIC PROGRAM FOR LONG-TERM CARE SERVICES

JUNE 14, 1990

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The Pepper Commission Reports

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PEPPER COMMISSION REPORT

Recommendations of the Pepper Commission Regarding a Public Program for Long-Term Care Services

THURSDAY, JUNE 14, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting will come to order.

First of all, I would like to apologize to my colleagues, to Senator Rockefeller, and to everyone here for my tardiness in getting this meeting started. I tried to get here as quickly as I could, but I just wasn't able to get away from another meeting as fast as I would have liked.

Today, the subcommittee meets to review the recommendations of the Pepper Commission regarding long-term care reform. It was my pleasure to serve as a member of this panel and help fashion the plan the Commission ultimately adopted. While the proposal may not be everyone's first choice, I believe it is the best choice available to us today.

For years now, we in Congress have heard the pleas of elderly and disabled Americans and their families. They are concerned because Medicare pays for only limited nursing home care and community services. They are fearful because Medicaid—the only public program that helps with nursing home bills—requires impoverishment as a condition of receiving assistance. And they are worried that the private insurance coverage that is available is beyond their reach.

As a result, their message to us is always simple and clear: the system is not working. It's not working for those who need services, it is not working for families and friends trying to provide services. And it's not working for Federal and State governments that pay for services.

For years now, we in the Congress have been promising to fix this broken system. We acknowledge Americans need something better. We know Americans want something better. And we pledge that Americans will have something better . . . sometime in the future.

But with the Pepper Commission plan, we can take the first real steps into that future.

We can put in place a home care benefit that will provide help with personal care to severely disabled Americans of all ages. We can put in place upfront coverage for the first 3 months of nursing home care to enable those who can, to return home without facing the financial devastation of even a short stay. And for those requiring additional institutional care, we can put in place a program to assist with nursing home bills that prevents impoverishment and preserves dignity.

Making this plan a reality won't be easy, and it certainly won't be cheap. But when I look in the faces of families struggling to care for an aging parent or a disabled child, I am firmly convinced that Americans are ready and willing to make the necessary commitment.

There are no more excuses to explain our delay. We have before us a blueprint for action. It is time to move forward.

Before calling on our first witness today, I want to recognize colleagues for opening statements.

Mr. Bliley.

Mr. BLILEY. Mr. Chairman, I have a statement, but I will yield to my colleague, the gentleman from Florida, who has a markup going on at this time to let him go ahead of me.

Mr. BILIRAKIS. Thank you, Mr. Chairman, and I appreciate Mr. Bliley yielding to me.

We are contacting the Energy and Power Subcommittee upstairs, Mr. Chairman, to find out what is going on with the markup, and I will try to stay here as long as they don't need me.

I am pleased, Mr. Chairman, that our health subcommittee is continuing to review the recommendations of the Pepper Commission. Because I represent, as you know, such a high number of older persons, I am especially interested in discussing issues surrounding legislation health care proposals.

Before I begin, however, Mr. Chairman, I do want to take this opportunity to say that here we go again, trying to find short-term solutions to a long-term problem. As long as we keep trying to revamp bits and pieces of our health care system, keep putting out these small fires—or at least we think we are putting out these small fires—the longer it will take to do what I think is really necessary, and that is overhauling our entire health care program.

I like to think that long-term health care should be a part of our overall revamping of the entire health care picture. But before we do that, Congress needs, to take the time to study the national health programs of other nations. It would be particularly interesting to see how these countries deal with the aging population and what legislation health care alternatives are available.

We know long-term health care is a top priority for older Americans. For example, last year when Congress considered repealing the catastrophic health law, seniors told me they did not want or need catastrophic benefits, what they really needed was comprehensive, long-term, health care coverage.

In the past, I introduced a bill entitled "The Elderly Americans' Economic Security Act," which would provide a tax incentive for keeping families together. I think that is part of the solution. The

legislation would amend the Internal Revenue Code to provide a tax credit for families choosing to care for elderly members in the home rather than institutionalizing them. The head of the household would be able to claim any and all health care expenditures for an elderly dependent as a tax deduction, just as a child dependent would be treated.

Another component of the bill involves doctors and nurses, and it just might bring back the house call. A tax credit would be provided to those doctors and nurses who, in their spare time, donate time and energy to provide care for those elderly in the home who cannot take full care of themselves.

Finally, the bill would allow tax-exempt withdrawals from IRA's for the purpose of long-term health care, and others have introduced legislation to do the same thing. Amounts paid for custodial care in or out of nursing homes or the insurance premiums would be included.

This bill, Mr. Chairman, provides an incentive, as I said earlier, for a new togetherness for the American family as well as an alternative to costly institutional care.

I have had seniors tell me that the last thing they want is to become a burden on their family—I am sure we have all heard that—but in many cases older persons are given little choice but to depend on their relatives for assistance. This presents a difficult situation for both the family members and a sick person because it forces families to make emotional decisions, and I believe the legislation that provides assistance to these families is a positive step.

Mr. Chairman, the Pepper Commission deserves much credit, as you do, for having been a very integral part of it, because through its report the long-term health care dialogue has been reignited. Once again, the biggest problem facing us today is, how do we finance a comprehensive long-term health care package? I am hopeful that our witnesses will be able to shed some light on this particular segment of the long-term health care debate and share with us some of their ideas on what steps they believe we can take toward solving this problem.

Again, Mr. Chairman, I do appreciate your holding this hearing, and I plan to be here as much as I possibly can, and, again, I appreciate Mr. Bliley yielding to me just in case I might be called away at any moment.

Thank you, sir.

Mr. WAXMAN. Thank you very much, Mr. Bilirakis.

I would like to now recognize Mr. Bliley for his opening statement.

Mr. BLILEY. Thank you, Mr. Chairman.

The problem of long-term health care for our Nation's elderly is one of the most important issues that our committee will face. In less than a decade, 33 million people, 12 percent of the U.S. population, will be 65 or older, and we face the fact that something must be done for these people. A very small percentage of those 65 to 75 require long-term care services, but the likelihood that long-term care will become necessary increases with age.

Once a person's resources are depleted due to this care, where are they to turn? To private insurance? To Medicare? These two categories cover only 3 percent of long-term care. Almost one-half

of our nursing home residents have to rely upon Medicaid to pay their bills.

How can we most efficiently and cost effectively address the problem of how to look after our elderly? This question applies to our disabled as well. What is the best way to get them the help they need?

I thank the witnesses we have before us today for coming to testify and look forward to hearing from them.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Bliley.

Mr. Fields, do you wish to make an opening statement?

Mr. FIELDS. No, Mr. Chairman; thank you.

Mr. WAXMAN. Thank you.

We are pleased to have as our first witness Senator Jay Rockefeller. We would like to have you come forward to the table.

Senator Rockefeller chaired the Pepper Commission, which has given us recommendations in the area of acute care and on the subject matter of today's hearing, the question of long-term care. I do want to acknowledge the fact that in this area—which is the catastrophe the elderly and disabled fear the most—we did come up with a broad, bipartisan consensus as to how to move forward. I would like now to have Senator Rockefeller present to us the Pepper Commission's on long-term care reform.

We are pleased to have you with us.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM THE STATE OF WEST VIRGINIA, AND CHAIRMAN, PEPPER COMMISSION

Senator ROCKEFELLER. Thank you, Mr. Chairman. I want to not just thank you in the customary manner for holding these hearings but to genuinely mean it when I say it.

I came from a morning discussion which reflected, I think, some of the gloom and doom going on around Washington right now because of a budget summit that doesn't seem to be moving, and everybody is saying we are not going to be able to get anything done this year.

I don't buy that, and you don't, and I think that is one of the reasons that you are having this hearing, because you are determined to see things happen in not just long-term care but access to health care and other things which you so totally and helpfully to this particular neophyte chairman, of the Pepper Commission, that is, you helped me so much.

We didn't go through that year-plus of incredibly hard work just for the fun of it, we did it because we want action to take place, and if there is anything where cost effectiveness, trying to do something smart now and saves money later, is true, it is in the health care field. As has been reflected in the earlier comments of some of those who have spoken, the problem is only getting worse.

I really thank you for, just right in the middle of all of this stall of the budget summit, holding this hearing, because I am determined, and you are determined, and I think your committee is determined, to see something happen with respect to the Pepper Commission work and have it turn into legislation, and I believe it

will happen; I believe it will happen. It may take a post-November special session, and I would welcome that. I can think of nothing better I would like to do in the months of November and December than to be back here fighting for health care, if that is what it takes, if that is what it takes.

I want to also before I start—and I promise to be brief—to thank you again, Mr. Chairman, and also Mr. Wyden, for your leadership on this side on the Medicaid Home and Community Care Options Act, which is absolutely essential. It is something which is affordable. It would start out as a modest amount, which we fought for last year, which I thought we were going to get last year, but which didn't quite happen. It is to help the poor and the frail elderly. It is one step, but it is an enormously important step, in using Medicaid, trying to get away from its institutional bias more towards the home health care bias, giving States a much easier way than the 2176 option that they now have.

On long-term care, Mr. Chairman, as you know very well, virtually nobody in this country has security when it comes to the physical and economic tragedy that strikes when long-term care is up against the American family. We have listened in the Pepper Commission to scores of families and scores of tragedies, talking about their problems facing long-term care.

The one that I will relate this morning is the one of Charles Keeney of Charleston, WV, caring for his father who has Alzheimer's disease; that is not exactly a 9-to-5 disease, that is all encompassing, all debilitating, not just for the victim but also for the family. Because he is a good son, like kids hopefully would be, he moved his parents, brought them back from Ohio to Charleston, into the house next to his own; he got that house.

Now, because of caregiving to the father—the mother can't really take care of the father—he is on his second or third mortgage. They haven't had a vacation in several years, the Keeney family. He has been saving money to send his son to college at West Virginia University. That has now gone; that money is now taking care of his father with Alzheimer's. And he is doing the right thing, but the American system isn't doing the right thing by him.

In all, between 9 and 11 million Americans of all ages—it is not just people 65 and older, it is all ages—need long-term care, and we know that what we have in place to help them cope with long-term care in this country now is wholly inadequate. We understand that, and the burden falls on family members, and we just let that continue and decline to take action, coming up with all kinds of excuses.

Medicare, which is meant to serve the medical needs of the elderly and disabled, is just—you know, forget it when it comes to long-term care; it is virtually no help at all; I think it pays maybe 2 percent at most. Medicaid is doubly flawed, one, because a person has to go into impoverishment before Medicaid even becomes a possibility, and then, when that happens, the institutional bias goes to nursing homes, and that is incredibly inexpensive, and that is not necessarily where people want to be or ought to be.

Private long-term care insurance is growing very fast, but the affordability of it is a major problem. It sticks in my mind—and I am

not totally sure that I am correct—that there are less than a million Americans that have private long-term care insurance at this point.

So, as a result, more than half of the costs of nursing home care come directly out of the pockets of the American family, and the problem, as has been mentioned, is getting much, much worse and very much faster.

We are not growing as old as quickly as Japan is—they lead the world in that too—but we are not far behind, and in the age of 85 and older, as you know, between now and the year 2030 it is going to be a 500 percent increase, from 2.5 million Americans to 12 million Americans, and you talk about a long-term care bombshell just in that section of the population.

One conclusion reached unanimously by the Pepper Commission was that the country needs an insurance-based strategy, and that is that we need to treat long-term care as an insurable event whose risks can be spread through the public sector and the private sector, both.

Now we looked at lots of options, as you know, Mr. Chairman. One option was to improve Government protection for low income people, but that still remains a two-tiered system, keeping some of the problems of those that cannot afford insurance and, therefore, the dependency upon the welfare-based approach. We rejected that properly.

Another possible route, and, frankly, one which the chairman preferred—the chairman that I am looking at preferred—and that was comprehensive, total comprehensive insurance for all long-term care services. I would have preferred it too, but it struck some of us that it was too expensive, it would have been $60 billion, and if we wanted to get something enacted, which was the hallmark of the Pepper Commission, to do something which was enactable, something which was doable, something which was practical and could get through Congress and get by the President, we did not pick that direction.

What we did recommend, by an 11 to 4 vote, which I call unanimous—that is my definition of a unanimous vote—was a new and unique combination of the public and private sector initiatives that will assure adequate long-term care protection for all severely disabled Americans. We were fairly rigid about that.

There was a question, should there be three ADL's? should there be two ADL's? We picked three ADL's, and I think the chairman would have preferred two ADL's, and so would I, but then there was a matter of cost, and so by picking three ADL's, again, trying to think of something that we could get past Congress, through the Congress, as soon as possible, first, we recommended a comprehensive universal insurance program like Medicare and Social Security for home care and community-based care for the first 3 months.

If a nursing home was involved, then we also recommended a social insurance program, non-means-tested; home health care, non-means-tested, social insurance; the first 3 months, non-means-tested, social insurance; and no discrimination in terms of age or income; it covered all income, it covered all ages. Individuals would help pay, 20 percent coinsurance, but there would be protection for low income, as the chairman well knows.

Why did we pick the first 3 months for social insurance? We could have picked 6 months. That would have been better, but it would have also been much more expensive. We picked the first 3 months, because about 45 percent of all seniors who enter nursing homes are out before the end of the first 3 months, and it was the view of the Commission that we don't want to take people—let's say somebody who is recovering from a broken hip, they go to a nursing home, and they get financially devastated there by the high cost of a nursing home. Let them go recuperate there and then be able to get back into the home, back into the mainstream, with their finances fundamentally intact; therefore, the social insurance program.

Nursing home costs range from $1,000 to $3,000 a month, and seniors, while they are in a nursing home, have to continue paying mortgage payments and other expenses. So we wanted to make sure they had the resources so that when they came back out of the nursing home they would be able to continue with independence and with confidence and dignity.

For longer nursing home stays, the Pepper Commission recommended an ample floor of financial protection, and I think we did precisely the right thing there. We, again, don't want to dehumanize people by making them spend themselves into impoverishment so that they qualify for Medicaid, so we set up a proposal that there was a floor beneath which seniors, or anybody of any age, could not fall. They would get to keep their house, and, if they were single, $30,000 of assets or savings, or, if they were a couple, $60,000 of assets or savings, again, plus home. So that is the floor.

Freedom from fear, we call it, freedom from fear forever more, and if they are above that floor, then they use the private insurance market, but then we help the private insurance market by allowing premiums to be treated as a health benefit. That is something the insurance industry wanted, and we gave that to them, because we want this to be an insurable event and insurance to become more affordable.

So the Government would pay for the social insurance part of the program, and the home care—that is, in the initial 3 months nursing home stays—and States would share in the costs of longer nursing home stays. We did this over a 4-year phase, Mr. Chairman, and I could go into that if members want to.

The departure from a pure social insurance in the case of long-term home stays was done because it reduces by half the cost of the same, but, nevertheless, the cost is substantial, $43 billion. That translates into about $4.50 a week for every nonpoor adult in this country. But we are already spending massive amounts of money under our present system. In 1985, we spent $45 billion, but, of course, that was mostly paid for by the families and the victims themselves.

Public opinion polls show that there is strong evidence that Americans want this kind of protection. As the gentleman mentioned before, that was one of the messages of catastrophic, that long-term care was what they were really talking about. That is not what they meant when they talked about catastrophic; they meant long-term care and that perhaps, in fact, Americans are

willing to pay for it. If we in the Congress and the White House are willing to face up to that kind of thing, Americans certainly are.

So I will conclude there, Mr. Chairman, but I want to again say that the Pepper Commission has submitted its report, so the easy part is done. Now we have got to get this stuff into legislation, and we have got to get it there as fast as possible. We tried to come up with not ideal solutions but workable solutions, and now we need serious legislative attention, the kind that you, Mr. Chairman, give on a daily basis. I want to see this pursued. I am sick and tired of seeing people wiped out financially, emotionally, psychologically, families, through this ridiculous system of long-term care that we have, and I thank the chair.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to testify today on the long-term care recommendations of the Pepper Commission. It is particularly fitting that this is my first statement to a Congressional panel on these recommendations, since it is chaired by the able gentleman from California, Henry Waxman. Not only was his contribution to our Commission's work invaluable, but his contribution to how well the Chairman of the Commission understands health and long-term care issues was profound.

This morning we're here to discuss one of the most widespread health-related problems in America today: the lack of protection against the need for long-term care.

And before I discuss the recommendations of the Pepper Commission on this subject, permit me, Mr. Chairman, to thank you and the gentleman from Oregon, Mr. Wyden, for your leadership in the House in pursuing a proposal I am sponsoring in the Senate. Our bill would make it easier for states to offer home and community services, and eliminate the need to apply for a special waiver from the Health Care Financing Administration. S. 1942 and H.R. 3933 represent one step—but a meaningful, desperately needed step—toward the ultimate goal of long-term care coverage for all Americans. It would bring immediate relief to some of our nation's neediest disabled older Americans. I hope we will be able to act on these bills this year.

The issue of long-term care reform is, in a sense, even tougher than the other major issue before the Commission, that of providing health care for the uninsured. At least in health care there is an insurance system, a combination of public and private coverage. It is certainly not without flaws, but 85 percent of the population is covered. In a sense, our job was to find a way to plug the other 15 percent into a workable, reformed structure.

By contrast, there is no real system into which to plug those in need of long-term care protection. Virtually no one in America is protected against the physical and economic tragedy that might come with a long-term care need. In its hearings, both here and around the country, the Commission heard from scores of families whose lives had collided with that harsh reality.

We heard from Jim and Rebecca Schienle, from Los Angeles, who cared for his frail mother for several years in their home. But when the caregiving burden became too great—both financially and emotionally—they were forced to place her in a nursing home. She resented it; they were racked with guilt. But they couldn't afford to pay for care at home, and there was no government help available.

There were Deborah and Scott Russell, from Michigan, whose seven-year-old son needs constant care for a variety of birth defect-related problems, and has almost exhausted the $500,000 lifetime limit in his parents' insurance policy.

Mrs. Edrell Trickle from Arkansas has been nearly forced into bankruptcy paying for her husband's nursing home bills. Over the past few years, the Trickles have paid over $60,000 from their own savings on the cost of his care.

And I was especially touched by Charles Keeney, from my own state of West Virginia. He too was caring for a frail parent, his father, who had Alzheimer's Disease. He moved his parents into the house next to him in Charleston to make care easier. But the economic strain was so great he had multiple mortgages on his home, and the money set aside for one of his children to attend the University of West Virginia has been spent to help pay for his father's care.

In all, between nine and eleven million Americans of all ages need long-term care, that is, they are chronically disabled, and must depend on others for help in the basic tasks of daily living.

And we know that what is in place to help them and their families cope with their disabilities is meager at best.

—Medicare, our national health insurance program for the elderly and disabled, has little to offer to senior citizens and others who need long-term care assistance. The long-term care benefits covered under Medicare, such as home health care and skilled nursing home care, are designed for acute care, not long-term care. Medicare currently pays only 2 percent of the nation's bill for nursing home care and 7 percent of home health care expenses.

—Most of the burden of daily caregiving falls on family members. Over seven million family members, mostly women, provide constant care for elderly relatives.

—Medicaid will help in many cases, but is doubly flawed: it isn't available until the person needing help first is impoverished, and, in many states, long-term care assistance is available only in a nursing home. The so-called "2176 waiver" under which many states deliver home and community-based services under Medicaid has been extremely difficult to obtain from the HCFA bureaucracy. That is why the bill I have sponsored with Mr. Waxman and Mr. Wyden is needed in the first place.

—While there have been dramatic increases in the number of Americans who have purchased private long-term care insurance policies, a critical question still unanswered is the total number of Americans who would ever be able to afford private insurance. In any event, it can be expected to take several decades before any significant proportion of the population could get private coverage, and the savings in Medicaid would not be all that large even then.

—Today, more than half the cost of nursing home care is paid for directly out of pocket by "victims" and their families. Out-of-pocket spending—which means the income, savings and other assets of the disabled and their families—has been growing as a share of the total, while Medicaid has been declining.

Looking to the future, it is easy to see why Americans' need for long-term care will expand rapidly. There are at least two important reasons for this.

First, we know that the need for long-term care is greatest among the elderly, and especially among the oldest of the elderly. Between now and 2030, the number of persons age 85 and over will increase almost fivefold—from 2.5 million to as many as 12 million.

Second, medical breakthroughs and high technology may continue to extend the lives of more developmentally and physically disabled people. We will need to provide care to more low-birthweight babies, probably for longer periods. And we are just beginning to recognize the long-term care consequences of the AIDS epidemic.

The Pepper Commission unanimously agreed that the country needs an insurance-based strategy—that is, we need to treat long-term care as an insurable event, whose risk can be spread through private or public coverage.

In addition, the Commission in its goal statement unanimously agreed that coverage should be affordable; allow freedom of choice of the type and setting of care; and assure high quality care, including consumer protection.

Of course, one can achieve that goal through more than one strategy, and the commission explored a number of them.

One possibility is to improve government protection for low-income people and promote adequate private insurance for the better off. One could extend to unmarried persons the improved Medicaid protection now afforded to spouses, and give better coverage of home and community-based services. And the tax status of long-term care insurance coverage could be clarified. But such a two-tiered system would mirror our unfortunate experience in health care. Too many people would be without private insurance and dependent on a welfare-based system, and that system might not give them access to quality care.

Another possible route would be to set up a comprehensive public insurance program for all long-term care services, both at home and in nursing homes. Many Commission members favored such a plan. It spreads the risk for all long-term care needs across the widest "risk pool," and carries the greatest assurance that the care will be there when it's needed, even if it's decades in the future. But the Commission was concerned that this strategy would spend many public dollars on giving unlimited protection for assets for those who could afford to protect themselves through private insurance. In an era of fiscal constraints, we concluded, that was probably not the most prudent use of the next federal dollar.

What the Commission recommended, therefore, was a limited social insurance approach.

Here are its principal features:

(1) Eligibility based on impairment. Anyone who is severely disabled qualifies for help, regardless of the condition that causes the disability, and regardless of age. The Commission strongly underscored its intent to help the 40 percent of those needing long-term care who, like the Russells' young boy, are under the age of 65.

(2) Social insurance for home care and the first three months of nursing home care, regardless of income and assets. This would protect an individual's ability to maintain his or her standard of living when they need long-term care, just as Medicare or private insurance does for those needing acute care. With help like this, the Schienles could possibly have continued to care for his mother .

(3) Individuals would help pay for this care, through a 20 percent coinsurance, and there would be protection for low-income people unable to afford these payments.

(4) For long nursing home stays, the Commission would protect life savings up to $30,000 for an individual, $60,000 for a couple. The Commission would also protect monthly income for a spouse or for maintaining a home, and recommends an improved personal needs allowance for the person in the nursing home. Income above the protected amounts would go toward the cost of the nursing home, and the public program would pay the balance. The Trickle family would be in much better condition under this program.

(5) The Federal Government would fully finance the social insurance part of the program—home care and initial nursing home stays—and share with the states the cost of longer nursing home stays. It would also develop standards for states to use in specific program aspects, and prescribe case manager budgets and payment levels to providers.

States would administer the long-term care program, and share in the cost of the long nursing home stays. To avoid sharp increases in state spending, the state's initial contribution would be the amount they are now spending on Medicaid long-term care. States would share in the growth of the cost of long nursing home stays over time. At the same time, we would build on the successful state experience in designing and operating home and community-based service programs.

(6) For those who have assets and income above those protected in the Commission plan, we recommend clarifying the tax treatment of private long-term care insurance, and strengthening consumer safeguards for those who might buy it. Our intent is remove the perceived barriers to private long-term care insurance, particularly for employers who offer long-term care coverage as an employee benefit.

(7) To allow time to put in place both the programmatic and fiscal capacity to make this new initiative workable, the program would be phased in over four years.

(8) In addition, the federal government would undertake substantial new research aimed at preventing, delaying and dealing with long-term illness and disability.

The departure from comprehensive social insurance for long nursing home stays reduces by half the cost of that part of the program. But new federal costs would still be substantial—about $43 billion a year once the program is fully phased in. That translates into about $4.50 a week for every nonpoor adult in the country.

Much of that money is currently spent for long-term care, particularly the nursing home portion, under the Russian roulette, victim-based system we now have.

Commission members recognized this, I think, and that's one of the reasons why these long-term care recommendations, unlike those in the area of health care, were approved by a solid, bipartisan 11 to 4 majority—even though the health care recommendations would require only about half the new federal expenditures of the long-term care plan.

Although public opinion polls are far from perfect, there seems strong evidence that Americans desire this kind of protection, want to see it provided through a government insurance program, and are willing to pay a realistic amount for it:

—A recent Yankelovich poll concluded that Americans are willing to pay $50 a month for the right long-term care package.

—A Los Angeles Times poll earlier this year concluded that Americans were willing to pay about $3 a week for nursing home care for the elderly only, which would be more than enough to finance that portion of the Commission's recommendations.

—A 1988 poll by RL Associates showed 73 percent of American voters willing to pay federal taxes amounting to about one per cent of their incomes to support a long-term care program.

I have said that the Pepper Commission's job was not to come up with ideal solutions, but to come up with workable ones. We can't continue to sweep this issue

under the rug, while millions of American families are pulled apart by long-term care needs, and millions more are threatened by the specter of a single nursing home stay wiping out a lifetime's worth of savings.

Thank you.

Mr. WAXMAN. Senator, thank you very much for your testimony and for you leadership on the Commission in dealing with the long-term care question.

There was a compromise reached on this issue and it was the kind of compromise that kept the integrity of all the various viewpoints on the long-term care problem. There were those of us who would have liked to have seen the problem addressed through a social insurance approach. What came out of this proposal was a recommendation for a social insurance approach for the home health care part of the program and for the first 3 months of nursing home care. I think we convinced those who weren't particularly enamored of the idea of social insurance that it made sense to that extent.

The Commission members were convinced, on the other hand, that we ought to target the program to those who are in need of some assistance. So we also recommended the establishment of a safety net. But the safety net is not the Medicaid safety net standard, which is far below what people would think protects their dignity. We recommended a standard that would keep people from being impoverished and humiliated through impoverishment before they had any kind of assistance.

The Commission also kept faith with those who want private insurance. There is a role for private insurance for those who want to protect their assets to pass on to the next generation. So, we do provide in the Commission's recommendations for the opportunity for those people who see the desirability of protecting themselves beyond what would be covered under the public program to buy private insurance.

So I think the recommendations of the Pepper Commission are as thought out as any I have seen from any kind of commission. And they are a good compromise that attracted what you called "almost a unanimous vote." They clearly represent a consensus as to how we ought to go.

For the record, I would like you to submit for the record, if you don't have it available to you today, the estimates of the number of Americans who would benefit under the Pepper Commission plan and the tables that provide a breakdown of the costs of the plan by type of service and beneficiary group as well as the set of assumptions used by the Commission in putting these estimates together. I think we ought to have this information in the record.

[The following letter was submitted:]

THE PEPPER COMMISSION,
U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE,
Washington, DC, August 8, 1990.

Hon. HENRY WAXMAN,
Chairman, Subcommittee on Health and the Environment,
Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR HENRY, Thank you again for the opportunity to testify before your subcommittee on June 14, to describe the long-term care recommendations of the Pepper Commission. In the course of that hearing, I promised to provide you and the sub-

committee with information about the costs and beneficiaries of our recommendations.

Updated estimates have just been developed for the long-term care package, and I am writing to share them with you.

Beneficiaries. Some 4.4 million persons would receive services each year under the recommendations—3.2 million age 65 or older, and 1.2 million younger persons. The vast majority—3 million—would receive services at home, while 1.4 million would receive help with nursing home care.

In the area of home care, we have better information about the elderly population needing assistance. The 2 million older people who would receive home care under the plan represent a doubling of the elderly who now receive paid home care. The 1 million people who would have purchased care in the absence of the public program will save almost $1,000 per user—a total of about $900 million.

Among nursing home users, every entrant will receive some public help under the Commission's recommendations—a vast improvement over current law, where three out of eight nursing home entrants receives no public help at all.

Of the 1.2 million entrants expected each year under the Commission plan, all of the "short stayers"—the 528,000 whose stays in the nursing home will last three months or less—will have their stays fully covered. They would, of course, be liable for the 20 percent copayment if they can afford it. Of the 672,000 with stays longer than three months, a majority—425,000—would have their life savings fully protected, and 93,000 of this group would have their full incomes protected as well. All of the rest would receive some assistance, after contributing assets and income above the protected levels.

Of course, in a very real sense, every American will benefit from the security of knowing that, if the need for long-term care arises—for themselves, their parents or their children—they would not be left to cope on their own.

Costs. After a phasein period, the Commission's recommendations in long-term care would require new federal spending of about $42.8 billion (expressed in 1990 dollars). Of that amount, some $31.8 billion would be for care for the elderly, split almost evenly between home care ($15 billion) and nursing home care ($16.8 billion). Among nonelderly beneficiaries, almost all new spending ($9 billion of the $11 billion) will be for home care. The total amounts to about $264 a year, or just over $5 a week, for each nonpoor adult in America.

Once again, thank you for your interest and advocacy in these important issues. If I can provide further information, please let me know.

Sincerely,

JOHN D. ROCKEFELLER IV, *Chairman.*

Mr. WAXMAN. I want to commend you for the work that you have done. I think we are ready to move. I would prefer that we address the long-term problem in the same context of dealing with the access to the health care problem. But it is my personal view—and I know this is not the view of everyone on our Commission—that there is no reason we shouldn't start meeting our commitment to the elderly and disabled in this country by moving forward to protect them from the catastrophe they fear the most and the one they thought they were getting protection from when we passed a bill called "catastrophic protection."

Let me turn to my colleagues, and start with Mr. Bliley, and see if he has any questions or comments he wishes to make.

Mr. BLILEY. No, thank you.

Mr. WAXMAN. Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, I don't think I have any questions of the Senator.

I commend you for taking time to be here this morning and for having chaired, of course, the Pepper Commission, and the work that you all did, the many hours that you put into it.

I am not sure whether you understood my opening statement. I sort of glossed over the point that I was trying to make, whereas we have got to approach this problem, and I think my district is probably more impacted by the lack of long-term care than any

other district in the country, so you know darned well that we have got to solve this problem. If we are going to be delayed and maybe never get to the point of revamping the entire health care system from A through Z, then, by all means, we have got to go fast forward on this particular issue.

But what concerns me, Senator, is that we concentrate on one particular area and then we think we are solving it; in some cases, we do; in some cases, like catastrophic, we don't, and we just really delay what I strongly feel we have got to be doing, and that is revamping the whole thing. A national health plan or national health strategy, in my opinion, is what is needed from A through Z, which would encompass, obviously, long-term care for all ages. This is basically the point that I keep trying to make on this committee, and I just wanted you to understand that.

Senator ROCKEFELLER. I understand, and I would say to the honorable gentleman that I don't really think that we are flitting around the edges on this proposal.

If I can indulge the chairman for a moment, under the Pepper proposal, 2 million Americans would get some home health care services, and very good home health care services, under the Pepper Commission, twice as many as receive that today. In other words, 2 million would be getting it, and there are only 1 million who would be getting it today. A million—two hundred thousand people enter a nursing home each year. All of these people would be eligible for the first 3 months of the social insurance program, as opposed now to about 180,000 who are currently helped one way or another by Medicaid or Medicare. That is quite a difference.

Then again, the question of freedom from fear. Every single person looking forward to not being shattered financially and being able to hold on to assets and savings and a home, I think, is not exactly tinkering at the edges; I think that is pretty basic stuff.

I had to say that, actually, in response to the gentleman's opening remarks.

Mr. BILIRAKIS. And I agree with you, but that question of fear also exists among millions of other Americans regarding other areas of the delivery of health care. Again, we may be solving this particular area but not addressing the rest of it. As far as I am concerned, it ought to be done in a comprehensive manner, covering all of the areas—some sort of a national health strategy which would include long-term care.

But in any case, my mind is open, because we do need some sort of long-term care solution, particularly covering Alzheimer's disease and some of these others that are not covered under Medicare.

Senator ROCKEFELLER. Thank you, sir.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Sikorski, do you have any questions before the Senator leaves?

Mr. SIKORSKI. No, I don't. I just want to commend him and acknowledge the incredible number of hours and time and resources that you and your staff and all the people involved have put into this and look forward to working with you on it.

Thank you, Mr. Chairman.

Mr. WAXMAN. Senator, we owe you a debt of gratitude for being with us and for the work you have done. We look forward to work-

ing with you on these questions in the future, and we are willing to stay here November and December if need be.

Senator ROCKEFELLER. And get it going.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you.

The witnesses on our second panel are appearing on behalf of a number of consumer and research organizations that have been very much involved in the issue of long-term care reform. We have invited them here today to give us their thoughts and comments on the long-term care plan proposed by Senator Rockefeller and a majority of the other members of the Pepper Commission.

Our first witness on this panel is Mr. Mike Rendish, who is appearing on behalf of the American Association of Retired Persons. Mr. Rendish serves as vote coordinator for AARP in the State of Washington.

We will hear next from Mr. Ron Pollack, executive director of Families U.S.A.

Testifying on behalf of the Commonwealth Fund Commission on Elderly People Living Alone is Dr. Karen Davis. Dr. Davis is the director of this study group.

And our last witness on this panel is Mr. Stephen McConnell, vice president of public policy for the Alzheimer's Association.

I want to welcome each of you to our hearing today. Your prepared statements will be in the record in full. What we would like to ask each of you to do is to limit your oral presentation to us to no more than 5 minutes. We will, unfortunately, have to be very strict about the 5-minute rule in order to get through the testimony of all of our witnesses and to allow an opportunity for the questions and answers.

Mr. Rendish, there is a button on the base of the mike. I can't tell if it is on. If the light is shining it is. We are pleased to start with you.

STATEMENTS OF MIKE RENDISH, WASHINGTON STATE VOTE COORDINATOR, AMERICAN ASSOCIATION OF RETIRED PERSONS; RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES UNITED FOR SENIOR ACTION; KAREN DAVIS, DIRECTOR, THE COMMONWEALTH FUND COMMISSION ON ELDERLY PEOPLE LIVING ALONE; AND STEPHEN McCONNELL, VICE PRESIDENT, ALZHEIMER'S ASSOCIATION

Mr. RENDISH. Good morning.

My name is Mike Rendish. I am the Washington State coordinator for the AARP Vote Program. I live in Pullman, WA.

Let me begin by commending you, Chairman Waxman, for your work as a very active member of the Pepper Commission and this committee for its continuing efforts to enact legislation that would make health and long-term care accessible even for the most vulnerable.

The need for the Pepper Commission work is clear. At present, we have no national strategy to meet growing health and long-term care needs. To be sure, we can be proud as a Nation of our achievements in health care, but those achievements are diminished by our failures: one, to guarantee access to basic health care services

for all Americans; two, to constrain the spiraling cost of health care; and, three, to provide long-term care to those who need it.

AARP is strongly committed to a comprehensive approach to affordable health and long-term care for people of all ages. Towards this goal, the association recently adopted 10 principles on health care reform that we are using to gauge the priorities of our members and to guide AARP's assessment of legislative proposals. These 10 principles are included in our written statement.

AARP believes that the Congress should establish a health care reform blueprint that reflects these principles. The Pepper Commission's recommendations move us much closer to this goal.

In the area of long-term care, we are pleased that the Commission has adopted a plan that would make long-term care benefits available to the people of all ages. AARP is also pleased that the Commission proposes a social insurance plan—that is, one into which everyone pays and from which everyone is eligible to draw benefits for home- and community-based care and for nursing home stays of 3 months or less.

On the other hand, the Commission's long-term care proposal raises several concerns for the association. The eligibility criteria for home- and community-based care services restrict coverage to persons limited in at least three activities of daily living or with equivalent cognitive impairment. This could be a very severe standard of disability, depending both on the definition of "cognitive impairment" and on the fact that a three ADL standard would cover only 750,000 noninstitutionalized people, leaving another 400,000 who have deficiencies in two ADL's.

We also believe that long-term care coverage based on social insurance principles should not be limited to the first 3 months of care. While AARP believes that the Commission has taken an important step forward in this proposal by removing some of the more punitive aspects of Medicaid spend-down, we are convinced that by moving away from a social insurance approach after 3 months of nursing home care, the Commission risks losing essential public support for its recommendation.

Our Social Security and Medicare systems have proven the value of a social insurance approach. They are able, at one and the same time, to preserve dignity and provide benefits to all and spread the costs across the population.

A 1989 study commissioned by AARP suggests that the fear of costs of a long-term nursing home stay greatly influences the willingness of the people to pay for long-term care benefits. In general, we believe that if, as the Commission proposes, financing for this package is broadly based, then eligibility for benefits should be as well. This concern is heightened because the Commission has advocated progressive financing which, when coupled with spend-down requirements, could lead to a situation in which those expected to pay the most would draw only a limited benefit from the nursing home plan. This reinforces the importance of knowing precisely how the plan would be financed.

Regarding the health care recommendations, AARP is pleased to note that there are many points of congruence between the association's views on health care reform and the Commission's recommendations. Specifically, we share concerns in the areas of univer-

sal access to both acute and long-term care, Government responsibility to establish and ensure access to a basic benefits package, a broad-based financing approach, and the potential for both employer-provided insurance and the public plan to exercise sufficient marketing leverage to permit effective cost containment.

The Commission has also left two crucial issues largely unaddressed in both proposals—financing and cost control. It is critical that the American people be provided with a proposed benefit structure and a means of judging how they will pay for these improvements. Until revenues are specified, it is impossible to make a definitive judgment on a total proposal.

In conclusion, AARP believes that the Pepper Commission has made significant progress toward designing an approach to provide all Americans with the health and long-term care that they need.

Thank you, Mr. Chairman.

[Testimony resumes on p. 38.]

[The prepared statement of Mr. Rendish follows:]

Statement

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

Introduction

I am Mike Rendish, AARP/VOTE Coordinator for the state of Washington. The American Association of Retired Persons commends the U.S. Bipartisan Commission on Comprehensive Health Care--the "Pepper Commission"--for its recommendations outlining a plan to provide access to health and long term care services for Americans of all ages. We welcome the opportunity to discuss challenges facing America today concerning access to health and long term care services. The Association is strongly committed to a comprehensive approach to affordable health and long term care for the people of the United States, regardless of their age.

The importance of the Pepper Commission's work is clear. While America is a nation of extraordinary resources and abilities, we have no national strategy to meet growing health and long term care needs or to ensure the quality and affordability of care. Further, it is critical to recognize that we all bear the costs of health and long term care, but in an uneven way.

We can be proud as a nation of our achievements in health care, but those achievements are diminished by our failure to guarantee access to basic medical and supportive care services for all citizens. Last year, approximately $600 billion was spent on health care in the U.S. Yet, even though this represents more spending per capita and a higher proportion of the GNP than in any other country in the world, serious barriers to care exist. Indeed, cost, itself, is a significant and growing barrier. Over 34 million Americans have no health insurance coverage, and millions more have inadequate protection. We have no system to assure access or to pay the costs of long term care, forcing individuals to rely on Medicaid, a poverty program. Residents of rural areas face shortages of physicians, nurses, and other health providers, transportation problems, and hospital closings.

These problems have serious implications for individuals, families, and for society as a whole. The lack or inadequacy of insurance forces many people to delay or avoid routine or preventive health care. This problem is not only harmful to an individual's health, but it also increases public expenditures when delay in treatment leads to expensive emergency care or hospitalization. The lack of a comprehensive system to finance long term care forces some chronically disabled individuals to go without services. It also impoverishes individuals and their

families, burdens the caregivers--family and friends--and strains Medicaid budgets. The Medicaid program was not intended to be a long term care program, yet long term care services account for over one-third of total Medicaid expenditures. Finally, the scarcity of health care providers and facilities in some rural and inner city areas severely impedes access to essential health care services such as prenatal care and emergency services.

AARP and Health Care Reform

In 1988, AARP's Board of Directors called for the development of a comprehensive Association policy position that could help move the country toward the goal of a reformed health care system that restrains costs and assures access to affordable, high quality health and long term care services. As a result, the Association's volunteer National Legislative Council recently adopted ten Principles on Health Care Reform. These principles will serve to gauge the health care priorities of our members and to focus and guide AARP's assessment of legislative and other proposals for health care reform.

AARP's Principles on Health Care Reform:

1. All individuals have a right to receive health care services when they need them. The public, through the federal and state governments, has the ultimate responsibility to develop a system which ensures reasonable and equitable access to needed health care services for all individuals.

2. All individuals have a right to reasonable access to health care coverage which provides adequate financial protection against health care costs. The public, through the federal and state governments, has the ultimate responsibility to develop a system which ensures universal access to health care coverage for all individuals, including individuals with disabilities or health problems. The health care system should be designed to ensure that all individuals are covered by a public or private health coverage plan. The government should establish a minimum benefit package to which all individuals are entitled.

3. All individuals have a right to high quality health care. The health care system should collect, analyze, and disseminate information about provider performance, health care outcomes, and the appropriateness and effectiveness of health care services. Quality assurance programs, such as peer review and professional licensure, should be strengthened and coordinated.

4. All individuals should have a reasonable choice of health care providers. Cost containment efforts should not unreasonably limit choice of providers. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

5. Financing of the health care system should be equitable, broadly based, and affordable to all individuals. Government, employers, and individuals share the responsibility to participate in health care financing. Our present method of financing health care should be replaced by fairer, more progressive financing approaches. Burdensome cost-sharing requirements (e.g., burdensome deductibles and coinsurance) should be avoided because they disproportionately affect the sick and the poor. The public, through the federal and state governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. Any financing method should preserve the dignity of the individual, regardless of his or her income level.

6. Methods of provider reimbursement should promote cost containment, encourage efficient service delivery, and compensate providers fairly. Health care providers should receive basically the same reimbursement for the same services within a given area, regardless of the payment source. The government should play a major role in establishing more uniform reimbursement practices and rates for health care providers. Health care providers share in the responsibility to be fiscally prudent.

7. Health care spending should be more rational and should be managed through more effective planning, budgeting, and resource coordination. The distribution and allocation of health care resources (e.g., capital, technology, and personnel) should encourage innovation, efficiency, and cost effectiveness, and should promote reasonable access to services. Federal and state governments should play a major role in planning and coordinating the allocation of health care resources.

8. All individuals have a right to a clean, healthy, and safe environment. The public health system (e.g., water and sewer service, environmental protection, occupational safety, etc.) should be strengthened to ensure the public's health, safety, and well-being. Public health efforts should: (1) increase citizen understanding and awareness of health, environmental and safety issues and problems; (2) improve access to primary and preventive care services, such as maternal and child health care, immunizations, and

nutrition counseling; (3) conduct health, environmental, and safety-related research; (4) coordinate the collection and dissemination of information about health, environmental, and safety issues; and (5) assure compliance with health, environmental, and safety standards.

9. Individuals share a responsibility for safeguarding their health. Individuals have a responsibility to educate themselves and take appropriate preventive measures to protect their health, safety, and well-being. The government, health care providers, and consumer organizations share in the responsibility to educate the public about health care. Differentials in contributions for health care coverage to encourage healthy behavior can be appropriate as long as they do not deny access to health care.

10. Long term care should be provided to all individuals through a comprehensive public program based predominately on social insurance principles (e.g., Social Security). Ultimately, the health care and long term care financing and delivery systems should be integrated.

In its effort to achieve health care reform, AARP believes it will be important for the Congress to establish a blueprint--the broad architecture--of a reformed health care system that reflects these principles. The Pepper Commission's recommendations move us much closer to this goal by moving us a long way toward the principle that all Americans should have a right to basic and affordable health and long term care coverage, and by suggesting a way to phase in necessary changes to implement this goal. Missing in this plan are the critical components of financing and effective cost containment.

AARP recognizes and accepts that incremental steps may be necessary to move this country toward the broader goal. But the "architectural blueprint"--the broad design--for ultimate system reform should determine the appropriateness of each step. A reformed health care system should not only constrain costs and cost-shifting and provide access to health and long term care protection; it should also reduce the complexity and fragmentation of our current system.

For many years the Association has sought to improve access to health care services for the underserved through legislation that is targeted to those most in need. While these steps alone are no longer adequate because they do not address the systemic problems with health care coverage in this country, this strategy has brought greater access to health care to some of those most in need. In recent years this has meant our strong support for a number of initiatives, including:

- expanded Medicaid coverage of pregnant women and children;
- the Medicaid buy-in to Medicare for poor Medicare beneficiaries;
- legislation to make the 2176 Home and Community-Based Waiver Program an option for the states, which we hope to see enacted this year;
- expansions in insurance continuation coverage under COBRA; and
- expanded Medicare benefits.

The Association also supports the following incremental steps to improve the Medicaid program: extension of Medicaid eligibility to all people living at or below the Federal poverty line; establishment of medically needy programs in all states; and improvement in Medicaid reimbursement for primary care physicians and specialists.

AARP has also been active at the state level, promoting efforts to: (1) create programs for the uninsured; (2) expand and improve Medicaid; (3) establish health care data collection systems that can monitor and compare cost and quality; and (4) provide incentives for health care providers to practice in rural areas.

In addition, the Association has committed its resources to the education of our members and the public at large on the critical necessity of reforming our health care system to ensure access to health care for all Americans. Further, the Association is funding several related studies including an exploration into the number of uninsured by state, the implications of employer-mandated benefits for low-wage workers and low-margin employers, and the use of demographic characteristics in small group rating practices.

Public surveys indicate that Americans view health care as a right, and that the public supports extending coverage to all uninsured people. AARP believes that making the necessary changes in our health care system to provide acute, preventive, and long term care services to all Americans, while restraining costs and improving the quality of care, is one of the major challenges for our nation in the 1990s.

AARP's Response to the Recommendations of the Pepper Commission

AARP commends the Pepper Commission and its chairman, Senator Rockefeller, for its plan to provide access to health and long

term care services for Americans of all ages. While the Commission failed to address several important issues in its proposal, the Commission's recommendations are consistent with AARP policy on many points. The following analysis reviews the strengths and weaknesses of the Pepper Commission's recommendations.

1. Long term Care

AARP has long stated that Medicaid, our primary governmental long term care program, is inadequate for several reasons: the Medicaid program covers little home care except through special waivers; among the services that Medicaid can provide, the degree of coverage varies dramatically from state to state; because it is a welfare program, Medicaid often robs families of dignity and independence; Medicaid does not enjoy the public or political support of programs from which everyone benefits, such as Social Security or Medicare; and, as a means-tested program, the Medicaid program is often viewed as administratively complex and intrusive.

AARP advocates a long term care system that provides universal coverage for comprehensive, coordinated long term care services for people of all ages. Our Principles on Long Term Care include the establishment of a national program that provides a range of institutional and community services. Eligibility should be based on functional and cognitive limitations. The program should assist informal caregivers and protect low income people from premiums, copayments and deductibles. It should be based on the principles of social insurance and shared risk. (A copy of AARP's Principles on Long Term Care is included in Appendix A.)

The Commission's long term care proposals are consistent with Association goals and policies in many respects. We look forward to the publication of the full report of the Commission so that we can more fully evaluate its proposals; however, the following discussion outlines the primary strengths of the Pepper Commission's recommendations on long term care.

- The Commission has adopted a plan that would make long term care benefits available to people of all ages. Though older persons constitute the majority of those in need of long term care, that need also extends to individuals of all ages.

- The Association is extremely pleased that the Commission proposes a social insurance plan for financing and providing services in the home and community and for nursing home stays of three months or less. We are also pleased that the Commission has recommended expanding coverage for those who are in transition from acute settings. The current Medicare program is far from

adequate in its coverage of these individuals and we believe that improvements in this area are critical to any comprehensive long term care program. In this regard, it is significant that over half of all nursing home residents are discharged within three months.

- The wide range of community-based services envisioned by the Commission would greatly assist severely impaired individuals, their families, and their caregivers. By including services such as respite care, transportation, and shopping, as well as basic health care services, the Commission's proposal supports the desire of almost every chronically ill or disabled person and his or her family to stay at home for as long as possible.

- The Nursing Home Program proposed by the Commission--which provides income and asset protection for nursing home residents after the first three months and is not based on social insurance principles--also makes it possible for a nursing home resident to return home if he or she is able to do so. In addition to providing a wide range of home and community-based services, the plan would set aside for at least a year 30 percent of the nursing home resident's income--not requiring that it be used to defray the cost of care in the nursing home--to maintain the home. The Nursing Home Program further protects financial independence by preserving substantial assets in addition to the home.

On the other hand, the Commission's long term care proposal also raises several concerns for the Association:

- The eligibility criteria for home and community-based services would restrict coverage to those individuals who are limited in at least three activities of daily living (i.e., eating, toileting, bathing, dressing, and moving from place to place) or have equivalent cognitive impairment. In 1989, an eligibility standard of limitations in three activities of daily living (ADLs) would have allowed only 700,000 to 800,000 persons living in the community to benefit from the program. This potentially severe standard of eligibility for home care becomes even more significant when coordination between the nursing home and home care benefits is considered.

  In addition, greater refinement in the definition of "cognitive impairment" is essential. Assessment tools used to measure cognitive impairment are not yet adequate to establish "equivalency" with physical impairment or to ensure that some of those most in need of long term care--such as Alzheimers patients--are eligible for this program.

Further, as we understand the Commission's proposal, all nursing home residents--without regard to limitations in ADLs or other criteria--are covered for the first three months of nursing home care. When combined, these two standards might create, ironically, an incentive for a person to seek nursing home care, despite the Commission's clear intent to encourage home and community-based care.

- The Commission would limit the length of nursing home coverage under the social insurance program to three months. While we are pleased that the Commission's recommendations reflect the need to expand coverage for individuals who are in transition into or out of an acute or long term care setting, we think this approach should be expanded to cover a full long term care program governed by social insurance principles.

- The Commission adopted a non-social insurance approach for its Nursing Home Plan (NHP) which covers home stays extending beyond three months. While AARP believes that the Commission has taken an important step forward in this proposal by removing some of the more punitive aspects of Medicaid spend-down that today stand in the way of personal dignity and independence, we are concerned that by moving away from a social insurance approach--one under which everyone pays and everyone is eligible for benefits--the Commission risks losing essential public support for its recommendation. Critical issues here will be whether the public perceives that this package will cover enough people and whether those who are expected to pay the most will receive a fair return on their contributions. Further, the Commission's call for broad-based and progressive financing and a non-social insurance approach stand in contrast. At a minimum, until the financing mechanisms are more clearly spelled out, it is not possible for AARP to make a definitive judgment on this proposal.

Findings from a study conducted by the Daniel Yankelovich Group (DYG) in the fall of 1989 strongly suggest that <u>the factor which most influences public support for a long term care benefits package and willingness to pay for that package is fear of the cost of a long term nursing home stay</u>. If people do not believe that a long term care package will address this fear, their willingness to pay for it declines sharply. The study, commissioned by AARP, included a survey with respondents representative of the total population of Americans age 18 and older. It also included focus groups and a technique borrowed from the commercial sector--"conjoint analysis"--which forces respondents to make choices among competing proposals. DYG found that Americans believe that nursing

homes are very expensive and likely to quickly wipe out a lifetime of savings. Thus, while the Commission's recommendations represent a significant improvement over current law, the public may not view the package of benefits and financing as one that would adequately protect them from impoverishment. (See Appendix B for more information on the DYG study.)

The NHP would be a major improvement over current Medicaid spend-down rules in that unmarried nursing home residents would be able to keep $30,000 in liquid assets rather than the current amount of $2000; however, the major drawback to any such program remains: eligibility for benefits based on income. Under the NHP, nursing home residents would have to declare their incomes and assets. After a stay of three months, a resident would have to begin spending his or her income and assets. For example, a typical unmarried resident with about $7000 in annual income (approximate median income for females over the age of 65, Current Population Survey, March 1989) and $32,000 in financial assets (Lewin/ICF estimate, based on 1984 Survey of Income and Program Participation, Census Bureau) would have to spend $3700, or slightly over half, of her income in the first year of a nursing home stay and $5800 in subsequent years. She would also be required to spend $2000 of her assets to defray the nursing home care costs.

- Closely tied to our concern about whether or not the public will perceive the long term care proposal to be adequate protection, we are seriously concerned that if, as the Commission proposes, financing for this package is broadly based, then eligibility for benefits should be as well. This concern is heightened because the Commission has advocated progressive financing, which, when coupled with the spend-down requirements, could lead to a situation in which those expected to pay the most would draw only a limited benefit from the Nursing Home Plan.

In addition to these general concerns, AARP has raised several specific questions about the Commission's long term care proposal. The answers to these questions might significantly influence the Association's position on this proposal.

(1) How would the Nursing Home Plan (NHP) and the Medicaid program interact? If a person could not afford the required copayment, how would coverage be provided? Would the Medicaid program have a role?

(2) Would current skilled nursing facility and home health Medicare benefits be retained? If so, how would they be integrated with the new program?

(3) What are the coverage criteria for the Nursing Home Program and the first three months of nursing home coverage? Could this create over-utilizaton or an institutional bias?

(4) What happens to beneficiaries who have 3+ ADLs when their functioning improves after rehabilitation to a two-ADL level?

(5) How does the 30 percent home maintenance allowance interact with the 200 percent protection for spouses under the NHP?

2. Universal Health Coverage

AARP is pleased to note that there are many points of congruence between the Association's views on health care reform and the Commission's recommendations.

- The Association's goal of universally available financial protection against the cost of acute and long term care is affirmed by the Commission.

- The Association shares with the Commission the view that it is the government's responsibility to establish a basic benefit package to which all individuals are entitled. The Commission includes important preventive services, and its proposal recognizes the need for a strong governmental role in health promotion, disease prevention, and health education programs.

- The combination of employer-provided and public programs provides the basis for universal coverage and assures that the government bears ultimate responsibility for providing reasonable and equitable access to basic health care for all Americans. The Commission estimates that roughly 100 million Americans would participate in the public plan--those currently enrolled in Medicare and Medicaid, the non-working uninsured not covered by Medicaid, and those employed by small businesses that decide not to provide benefits. We are pleased that the Commission creates the potential for both employer-provided insurance and the public plan to exercise sufficient market leverage to permit effective cost containment.

- AARP shares the Commission's concern about the problems smaller businesses and lower-income families face in securing affordable health care coverage. The Commission proposes subsidies for businesses with fewer than 25 employees and for families with incomes below 200 percent of the poverty threshold. The Commission's recommendations for reform of the private insurance market would also

increase the availability and affordability of insurance for small businesses.

- AARP shares the Commission's belief that funding for universal health coverage must be progressive and broadly based.

- The Association supports the Commission's recommendation that Medicaid be replaced with a broader public program that would improve the fairness of the health care system and eliminate the stigma of welfare.

On the other hand, although the Commission's recommendations collectively have the potential to substantially improve the plight of many of the uninsured, there remain some important issues that are inadequately addressed. AARP views the following items as weaknesses in the Commission's recommendations:

- The Commission would rely on incentives and benchmarks to encourage small employers to insure their workers. It would be important, in such a program, to ensure both that these incentives are meaningful and that the public program is adequate so that public program participants are not disadvantaged relative to those who receive employer-based coverage. This public program would, in our view, be insufficent if it were to become merely a new Medicaid program. A more effective and less costly strategy could be to apply the same rules affecting larger businesses to smaller employers, but provide such assistance as is necessary to make coverage accessible and affordable to small employers.

- The Commission would establish an employer-provided coverage target at 80 percent for small employers. If small employers do not meet this target, all employers are required to provide private insurance coverage or contribute toward the cost of coverage in the public plan. However, if employers collectively hit this target, no further action would be required on their part to cover the remaining uninsured. Again, the Association feels that this last provision has the potential of leaving a large number of small business employees uninsured. Further, there is no <u>automatic</u> mechanism for insuring this population, only a requirement that the Secretary of Health and Human Services develop a coverage plan for submission to Congress.

- The Commission's proposal would not guarantee reduced complexity in the present health care system. Health care coverage would continue to be provided through a number of insurance programs targeted to different segments of the

population. While private insurance would continue to play an important role in such a system, careful coordination and integration would be a critical administrative function if cost-shifting and serious discrepancies in coverage are to be avoided.

3. Financing and Cost Containment

Notwithstanding the Commission's broad approach to its mandate, it left two crucial issues largely unaddressed in both its access and long term care proposals: financing and the need to control costs. The Commission agreed that any financing to pay for the benefits it proposes should be broad-based and progressive. AARP agrees with these principles. These principles combined with the price tag on the Commission's proposals suggest only a few possible revenue options: an increase in income taxes, payroll taxes, or a value added tax. The latter two would require offsetting adjustments to protect low income individuals (i.e., payroll taxes and value added taxes generally place a heavier relative burden on lower income individuals; therefore, each of these revenue sources would need to be accompanied by protections that would ensure fairness across all income levels).

While we understand and sympathize with the Commission's reluctance to specify financing, it is critical that the American people be provided not only with a proposed benefit structure to address their health care problems, but also with a means of judging how - that is, through what revenue measures - they might be expected to pay for these improvements. Until revenues are specified, it is impossible to make a definitive judgment on a total proposal.

A substantial part of our current health care crisis stems from the fact that we have not effectively addressed those factors in our health care system that have allowed costs to rise at rates that are double and even triple that of general inflation. While the Commission considered proposals to help restrain costs, several proposals were subsequently dropped. We are troubled by the prospect that the Commission's proposals to extend needed benefits without including meaningful cost constraint mechanisms may lead to unnecessarily higher costs to both insurers and taxpayers, particularly when there is strong evidence that much of our present health system is inefficient.

Where We Go From Here

In conclusion, AARP believes that the Pepper Commission has made a strong step forward in constructing the architecture that this nation needs to provide Americans of all ages and incomes with the health and long term care that they need. However, as

we have discussed this issue with AARP members nationwide, the need for continued and aggressive public education and debate is quite clear. Most Americans have criticisms about our health care system, and poll data indicate that one-half of the population is uncertain if they could afford good medical care if they became critically ill (Los Angeles Times, January 1990). This ebbing confidence in our health care system is reflected in several ways: some see their individual problems with the system, but do not view these as symptoms of broader, systemic problems; some believe that the system needs to be reformed, but cannot identify what the problems are that require correction; and still others misidentify the problems (e.g., the LA Times poll indicated that while the public believes that the poor and the old have the greatest problem with health care coverage, the significance of the problem that exists among children, Latinos, and American Indians goes unrecognized). In general, however, while Americans believe that problems with the system are extensive, they also have faith that the American health care system can provide the best care available, if one can afford it.

AARP will continue and increase its public education efforts to help explain this crisis that can only intensify as health care costs rise, as the number of the uninsured and underinsured Americans grows, and as the population ages. We call upon the Congress to help lay the groundwork for solving this serious problem by holding extensive hearings around the country that demonstrate the extent of the problem and focus public attention on the choices that must be part of a solution. We must seek the answers to several questions:

(1) Has the Pepper Commission identified an appropriate and acceptable benefit package? What, if any, changes are desirable?

(2) Are we willing to pay the cost of these benefits, not only in the aggregate, but as individual taxpayers?

(3) Are we, as individual consumers of health care, prepared to adjust our patterns of use and coverage? Are we willing to make tradeoffs that will be necessary to achieve access to health and long term care coverage for all Americans?

AARP believes that we have an obligation to put these and similar questions to the American people, and during the coming months we will continue to do so. Reform of our health care system will only be possible as the American people understand both benefits and costs, the risks of inaction, and the opportunities in comprehensive reform. We are confident that these questions will be answered in the form of clear and strong messages to our elected officials. Public education activities in the community and involvement in Congressional and state elections this fall and in the 1992 Presidential elections offer excellent opportunities for public debate about these important questions.

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Appendix A
AARP Testimony
June 14, 1990

AMERICAN ASSOCIATION OF RETIRED PERSONS
PRINCIPLES ON LONG TERM CARE

1. A national long-term care program should provide a comprehensive range of institutional and non-institutional health and social services. Long-term care should be provided in the least restrictive setting possible.

2. Long-term care services should be available to all people who need them, regardless of age or income. Eligibility should be based on cognitive and functional limitations, such as dependencies in eating, bathing and dressing.

3. The new public program should assist, not replace, current informal caregivers. Families and friends need access to supportive services so that they are not unreasonably burdened and can continue to provide care.

4. The principles of social insurance and shared risk must be extended to long-term care through an expansion of the Medicare program. By spreading the cost across the entire population, protection can be provided in a more affordable, equitable manner for any one person.

5. The new public program must be self-financed so that it does not increase the federal budget deficit.

6. The new long-term care program should be financed primarily through taxes that could be earmarked to a trust fund for this purpose, making the Medicare payroll tax an option. Additional revenue sources could include increased estate and gift taxes, income taxes and modes premiums.

7. Protection for low-income persons must be provided against the cost of premiums, deductibles and copyaments.

8. Implementation of the public program must be phased-in to ensure orderly development of the new system and all of its services. The first priority should be expansion of home and community services.

9. Cost containment mechanisms must be built into the system. Modest deductibles and copyaments should be included in the system, along with strong care coordination.

10. Provider reimbursement must be adequate and structured to ensure high quality care and access for all.

11. The new public program must provide a solid foundation for protection, upon which the private sector can build, with supplemental coverage of copayments and deductibles, as well as additional services not covered under the public program.

Appendix B
AARP Testimony
June 14, 1990

LONG TERM CARE IN AMERICA:
PUBLIC ATTITUDES AND POSSIBLE SOLUTIONS

A Study Conducted for the
American Association of Retired Persons
by
The Daniel Yankelovich Group, Inc.

QUESTIONS AND ANSWERS

Background:

In the summer of 1989, the American Association of Retired Persons (AARP) commissioned the Daniel Yankelovich Group, Inc. (DYG) to conduct a major research study on American attitudes toward long term care and possible solutions to the problem posed by the increasing need for affordable and readily available long term care. The study, titled "Long Term Care in America: Public Attitudes and Possible Solutions," and conducted throughout the fall of 1989, focused on several questions that are fundamental to the public policy debate:

* What do Americans see as their LTC needs?
* What do they want to do about these needs?
* How much, if anything, are Americans willing to pay to solve the LTC problem?

In conducting this study, DYG used three methods of measuring public opinion: a traditional public opinion survey, conjoint analysis -- a technique borrowed from commercial market research, and focus groups. The study findings were based on a survey of approximately 1500 Americans, representative of the total population of adults 18 years of age and over. Adults age 50-64 and those age 65 and over were over-sampled to permit a close look at the concerns of older Americans.

Q. What are the major findings of "Long Term Care In America: Public Attitudes and Possible Solutions?"

A. Nursing home coverage is a must for any long term care program, public or private. It is the cornerstone of public support for a program and willingness to pay for that program.

Major Findings, continued:

Quite understandably, the cost of nursing home care leads to a preference for coverage starting immediately upon admission.

It is not that Americans look forward to, or even easily accept, the idea of being in a nursing home; indeed, nursing homes are intensely disliked by many Americans. Americans would much prefer home care. However, Americans believe that once a long term care situation exists, the nursing home is inevitable; i.e., home caregivers cannot cope beyond a certain point. Further, Americans believe that nursing homes are prohibitively expensive and likely to quickly wipe out a life time of savings.

> Note: See Figure 1, Page 7. This pie chart shows the relative importance of key factors in determining support for a long term care program, as found by the study.

Everyone -- not just the poor or older Americans -- should be eligible for a long term care program. This strong preference for universal eligibility is driven by traditional American sensitivity to fairness and, probably more importantly, self-interest, in that most Americans feel the financial threat of long term care costs and would want to be eligible for a public program, particularly if they are paying some of its costs.

Americans are willing to pay $50 per month for the "right" long term care package. They choose this option even though they were presented with the choice of paying nothing for long term care. Americans **do** realize that they will have to pay for a long term care program and $50 per month emerges as an acceptable price tag.

Americans are not confident about their ability to pay for long term care. **Before** being informed about the average annual cost of nursing home care, 53% of Americans say they are not very confident or not at all confident that they would be able to deal with the cost of LTC if a child, spouse, parent or they, themselves, needed it. **After** being told that the average annual cost of a nursing home stay ranges from $25,000 - $34,000, 73% say they are not very or not at all confident in their ability to cope with nursing home costs.

> Note: See Figure 2, Page 7. This graph shows how public confidence in ability to pay for long term care plummets after people are informed of the real costs of nursing home care.

Major findings, continued:

Experience with long term care is widespread. Two-thirds of Americans (66%) have had direct or indirect experience with long term care. Nearly one in two (47%) have had direct experience (a family member or self). An additional 19% have had indirect experience (a friend's involvement). Further, 40% believe that they are likely to have to find or provide long term care for someone within the next 5 years, and 46% say that they are likely to need long term care at some point in their lives. The study also shows that Americans who know more about long term care are most likely to support a government-based solution to the problem.

Americans strongly support a government-based long term care program; however, this is more a matter of realism than preference. Sixty-eight percent say they strongly support such a program; 88% say they support it. This support stems from the recognition that government is the only practical option, i.e., that only government can provide what Americans want at the price they are willing to pay, and not from a philosophical preference for a government program.

In fact, skepticism about government is deep enough that in an ideal world, Americans would prefer not to rely upon a government program to protect them from the financial burden of long term care. For many, private insurance would be preferable. However, the American public recognizes that:

* The cost of private insurance would far exceed the $50 per month price tag they are willing to pay. Most Americans could not afford the cost of private long term care insurance.
* Even for those who might be able to afford it, a private system would exclude many applicants.
* Those who could afford and qualify for it might not sign up for long term care insurance, leaving the need unaddressed.

There is remarkable consistency in attitudes across subgroups. While some notable differences do exist, Americans are considerably more alike than different in their views on long term care and long term care solutions. The differences of opinion among certain subgroups are logical and to be expected. For instance:

* Women are more concerned about and involved in the issue.
* For lower income Americans, the cost of any program is a more important factor.
* More affluent Americans are less concerned about what

Major findings, continued:

they will have to pay, but put extra stock in help for caregivers and in their own eligibility for the program.

* Those who have had direct experience with a long term care situation -- especially current caregivers -- place a special emphasis on the need for nursing home coverage.
* There is a relatively small, but clearly defined, group that rejects a government program on philosophic grounds and who can be expected to be vocal in their opposition to such a program.

There is a significant need for public information and education on the long term care issue. Americans, themselves, feel they are underinformed on the issue -- its costs, who will need it, what is available through Medicare, private insurance and the like -- and want to learn more. Moreover, they emerge as misinformed, with a substantial minority believing, for example, that Medicare does include coverage of long term care costs (33% of those over 65; 27% of 50-65 year olds). Further, those who know more are clearest in their support for a government-based solution.

Q. **Why are the results of this study significant?**

A. Over the past several years it became evident that a deeper, more comprehensive assessment of public needs, wants and priorities in the area of health care would be important in future public policy debates. For one aspect of health care -- long term care -- this study does just that. It is based on a unique approach to assessing public opinion that looks at what tradeoffs emerge as people make the complex decisions about what they really want and are really willing to pay for in the area of long term care.

The findings of this study can be used to help shape a long term care program for all Americans. But even before that happens, these findings can guide public education efforts so that people can make informed personal and public policy choices about long term care.

Q. **Why did AARP commission this study and how does it differ from other public opinion research on Long Term Care?**

A. In commissioning the study, AARP was seeking information on

* what Americans identify as their most important long term care needs;
* when faced with the complex array of options, what solutions they prefer to address these needs; and
* how much they are willing to pay to meet these needs.

The availability and cost of long term care have been on the national agenda for some time, and a number of public opinion surveys have looked at the issue. However, the current political climate -- in particular, the controversy over and eventual repeal of the Medicare catastrophic care legislation, suggested that a fresh approach was needed.

The Daniel Yankelovich Group study takes a giant extra step by supplementing traditional public opinion measurements with conjoint analysis, a technique borrowed from commercial market research. Conjoint analysis is a statistical method that is used to analyze the trade-offs people are willing to make in a complex decision. It makes possible a more realistic evaluation of public attitudes toward potential long term care proposals, and factors in the all-important question of how much Americans are willing to pay for long term care solutions.

Q. **How many AARP members were included in this study.**

A. AARP's members are age 50 and older. Of the 1490 individuals in this study, approximately 1000 are over age 50. 581 of these are AARP members. 268 of these members are between the ages of 50 and 64; 313 are over 65.

Q. **Does the importance of nursing home care in deciding what long term care solutions people want and are willing to pay for mean that people don't want home care to be part of a program?**

A. Despite the fact that Americans believe that nursing home coverage is a must for any long term care program, they do not look forward to, or even easily accept, the idea of being in a nursing home. Indeed, nursing homes are intensely disliked by many Americans and are seen as cold, dehumanizing and of erratic quality. They are not the solution of choice for meeting long term care needs. Americans would much prefer home care. However, they recognize that once a long term care situation exists, the nursing home is often inevitable -- and that home caregivers cannot cope beyond a certain point.

Further, Americans believe that nursing homes are very expensive and likely to quickly wipe out a life time of savings.

The benefits of home care are clear to most Americans -- the personalized care, the special warmth and attention. Yet home care is not seen as problem free. It can be devastatingly demanding for the relative or friend who is the caregiver. Another factor in this finding probably relates to the fact

that, correctly or not, home care is not seen as prohibitively expensive, but nursing home care is.

Q. **What is AARP's highest priority -- long term care or access to basic health for the approximately 34 million Americans who have no health insurance at all?**

A. The public policy debate over health care during the last several years has framed some new questions and challenges. While in some respects this nation's health care system is among the best in the world, many Americans are not getting the kind of care they need when they need it. This is not made any easier by the fact that there is no way of knowing when a person is going to need a certain kind of care -- whether it be doctor or hospital services, preventive care, prescription drugs, or long term care.

What is clear, however, is that the rising cost of health care stands out as the most significant obstacle to obtaining the affordable, appropriate and quality health care. We cannot address cost and the other shortcomings of our health care system in a piecemeal fashion. This study reenforces that real answers to these problems can only come if we view each of these concerns as part and parcel of a concerted effort to make health care -- whatever its form -- affordable and available to all Americans.

January 26, 1990

FIGURE 1:

RELATIVE IMPORTANCE OF LONG TERM CARE PROGRAM FACTORS

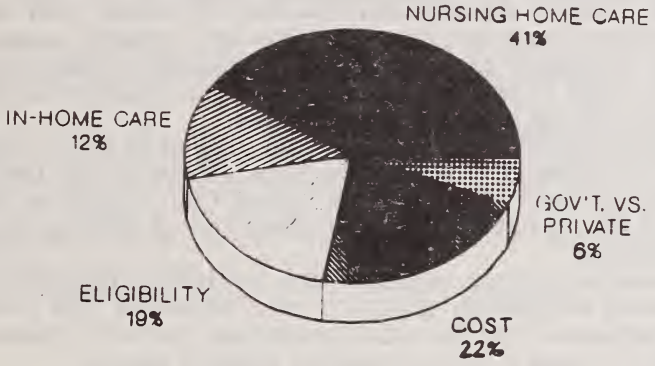
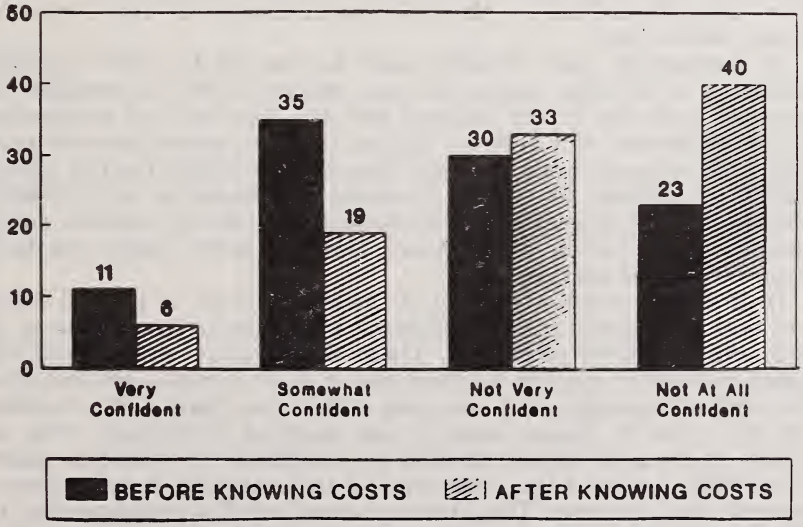


FIGURE 2:

CONFIDENCE IN ABILITY TO DEAL WITH NURSING HOME COSTS



Mr. WAXMAN. Thank you very much, Mr. Rendish. We very much appreciate that.

Mr. Pollack.

STATEMENT OF RONALD F. POLLACK

Mr. POLLACK. Mr. Chairman, members of the committee, I am pleased to testify today about the invaluable contribution of the Pepper Commission recommendations on long-term care.

The Pepper Commission developed recommendations that meet our most immediate long-term care needs from a variety of perspectives. The recommendations recognize the special need for publicly providing home care benefits while also providing meaningful financial assistance to the majority of persons needing nursing home care. The recommendations would make long-term care benefits equally available to persons of all ages.

The recommendations recognize that long-term care needs can best be met through a social insurance approach that covers all Americans in need of the services rather than relying on private insurance that is unaffordable and offers limited coverage to a limited population.

The recommendations recognize that low income persons with incomes under 200 percent of poverty need assistance with cost sharing requirements. And the recommendations provide increased protection for spouses of institutionalized disabled persons.

I would like to take a few minutes to describe the inadequacies of long-term care services currently available in the country.

The need that we have all heard expressed over and over again is the need for greater access to and affordability of home care services. In most States, there is not even a social safety net for those who need assistance with home care. Medicaid is virtually the only source of public insurance covering long-term care services. Only 4 percent of Medicaid expenditures in 1988 were for home health care.

A community care benefit must be one of the first building blocks of a national long-term care system. First, it provides for services that are in the highest priority demand and encourages the development of a delivery system that can serve those who can pay with private funds as well. Second, it provides for the affordability of services for which financial assistance is not currently available. Last, it redresses the institutional bias of current public policy which makes institutional services more easily available than home care services.

In 29 States and the District of Columbia, there is a social safety net that provides financial assistance with nursing home care to all who cannot afford such care. These States allow elderly and disabled persons to qualify for Medicaid if their incomes are less than the cost of nursing home care and if they only have limited assets. In the other 21 States, elderly and disabled individuals with incomes above a set dollar amount are ineligible for Medicaid assistance with nursing home costs even if their nursing home expenses exceed their incomes. The nursing home benefits recommended by the Pepper Commission would eliminate the inequities in coverage that currently exist from State to State.

The Pepper Commission recommendations aim to build a long-term care system in this country that is not dependent on private insurance to meet basic needs. This is very important since recent research by Families U.S.A. Foundation and others reveals serious flaws in the long-term care insurance market.

The cost of basic long-term care policies from nine leading companies averages $1,255 annually for those purchased at age 65, increasing to $2,879 for those purchased at age 75. Families U.S.A.'s study, The Unaffordability of Nursing Home Insurance, showed that 84 percent of older Americans could not afford these premiums.

Those individuals who have purchased a long-term care insurance are by no means assured that their long-term care needs will be met. We should not continue to hold much hope that private long-term care policies will get better. Only by adopting a social insurance approach to long-term care and spreading the risk across the entire population can we meet our long-term care needs in an affordable manner. We will be pleased to work with the committee to begin enacting the Pepper Commission recommendations.

[Testimony resumes on p. 51.]

[The prepared statement of Mr. Pollack follows:]

Testimony by

Ronald F. Pollack
Executive Director

Families USA
(Families United for Senior Action)

Mr. Chairman, Members of the Committee, I am pleased to testify today about the invaluable contribution of the Pepper Commission recommendations on long term care and the effect those recommendations would have on meeting the long term care needs of persons with disabilities, and of their caregivers.

Families USA (Families United for Senior Action, formerly Villers Advocacy Associates) joined with the American Association of Retired Persons three years ago to found the Long Term Care Campaign. Approximately 130 national organizations are members of the Campaign, and the Alzheimer's Association has joined Families USA and AARP as a major partner in funding the Campaign's work.

Our initial public opinion research convinced us that long term care is an unmet need for which Americans of all ages strongly feel a government program is the appropriate solution. From the moment we publicly announced the campaign to this day, the daily mail has brought heart-rending testimonies from persons with disabilities and their caregivers about the difficulties they have getting and providing long term care, and expressions of hope about what our campaign can accomplish. I know that you, too, hear these same strong feelings of despair, sacrifice and hope.

The Pepper Commission listened to these outpourings and responded with recommendations that meet our most immediate long term care needs from a variety of perspectives:

- o **HOME AND NURSING HOME CARE** -- The recommendations recognize the special need for publicly-providing home care benefits, while also providing meaningful financial assistance to the majority of persons needing nursing home care;

- o **CARE FOR THE DISABLED OF ALL AGES** -- The recommendations would make long term care benefits equally available to persons of all ages;

- o **SOCIAL INSURANCE** -- The recommendations recognize that long term care needs can best be met through a social insurance approach that covers all Americans in need of the services, rather than by relying on private insurance that is unaffordable and offers limited coverage to a limited population;

- o **PROTECTION FOR LOW INCOME PERSONS** -- The recommendations recognize that low income persons, with incomes under 200 percent of poverty, need assistance with cost-sharing requirements; and

- o REALISTIC GOALS -- The recommendations recognize that a public program must offer basic benefits, but cannot, given our country's current financial circumstances and other unmet needs, offer unlimited asset protection.

We could all feel much more secure about the future if Congress enacted the Pepper Commission's recommended long term care benefits. In the future, the program would hopefully be expanded to provide benefits to more persons with disabilities, for example persons with limitations performing two activities of daily living. We understand, however, the need to implement a national long term care program as soon as possible, and therefore the need to target the initial program to those with the most serious disabilities.

OUR CURRENT LONG TERM CARE SYSTEM

HOME CARE

I would like to take a few minutes to describe the inadequacies of the long term care services currently available in this country.

The need that we have all heard expressed over and over again, by persons with disabilities and by their caregivers, is the need for greater access to, and affordability of, home care services. In most states, there is not even a social safety net for those who need assistance with home care. Medicaid is

virtually the only source of public insurance covering long term care services. Very few Medicaid beneficiaries currently have access to home care services. Only 4 percent of Medicaid expenditures in 1988 were for home health care. Of Medicaid expenditures for the elderly, 5.1 percent in 1986 were for home health care.

These services are by no means uniformly available across the country. All states must offer home health care; twenty-six states offer personal care services through their Medicaid programs; but New York State alone accounts for 50 percent of Medicaid home health care spending. Nationally, about 500,000 Medicaid beneficiaries received home health services in 1988.

Currently states can make a wide range of home- and community-based services available to the elderly only by obtaining a Section 2176 or Section 1915(d) waiver from the Department of Health and Human Services. To obtain such waivers, states must demonstrate, using a rigorous methodology, that they will not be spending more than they would have spent for institutional care. Approximately 60,000 elderly beneficiaries received services under the Section 2176 waivers in 1986.

In many instances, it is easier for an individual to qualify for Medicaid institutional benefits than for community care services. Many states do not offer home- and community-based

services statewide. Some states do not allow individuals needing community care services to retain enough income to meet their basic needs in the community, or those of their spouse. Those same individuals can go into nursing homes, where their room and board and personal assistance needs are all covered by Medicaid.

A community care benefit must be one of the first building blocks of a national long term care system. First, it provides for services that are in highest priority demand, and encourages the development of a delivery system that can serve those who can pay with private funds as well. Second, it provides for the affordability of services for which financial assistance is not currently available. Lastly, it redresses the institutional bias of current public policy, which makes institutional services more easily available than community care services.

NURSING HOME CARE

In 29 states and the District of Columbia there is a social safety net that provides financial assistance with nursing home care to all who cannot afford such care. These states allow elderly and disabled individuals to qualify for Medicaid, if their incomes are less than the cost of nursing home care and if they have only limited assets. In the other 21 states, elderly and disabled individuals with incomes above a set dollar amount are ineligible for Medicaid assistance with nursing home costs, even if their nursing home expenses exceed their incomes.

Recent research in Florida is beginning to bring the consequences of this policy to light. Florida officials estimate that they deny Medicaid nursing home coverage to approximately 4,000 individuals a year with incomes above the fixed dollar eligibility limit. Future results of the research will provide information about the health and financial status of these individuals.

The nursing home benefits recommended by the Pepper Commission would eliminate the inequities in coverage that currently exist from state to state. Coverage for short-stays would be universally available to those with serious disabilities and longer-stay coverage would be universally available for those with a moderate amount of assets and below.

THE LIMITATIONS OF PRIVATE INSURANCE

The Pepper Commission recommendations aim to build a long term care system in this country that is not dependent on private insurance to meet basic needs. This is very important, since recent research by Families USA and others reveals serious flaws in the long term care insurance market.

Long term care insurance products are expensive and unlikely to be affordable by a large majority of senior citizens. The cost of basic long term care policies from nine leading companies

averages $1,255 annually for those purchased at age 65 and increases to $1,808 for those purchased at age 70, and to $2,879 for those purchased at age 75.

Families USA Foundation's study, The Unaffordability of Nursing Home Insurance, showed that 84 percent of older Americans could not afford those premiums. Two-thirds of older Americans could not afford even the lowest priced basic nursing home policy. To determine affordability, our study used a standard more conservative than that used by the Reagan Administration to define a catastrophic health cost. The Reagan Administration defined health care costs in excess of 10 percent of a person's income as "catastrophic." Our standard took into account value of individuals' assets, as well as their income.

Those individuals who have purchased long term care insurance are by no means assured that their long term care needs will be met. Families USA Foundation's report on insurance industry abuse of frail elders illustrated the many problems purchasers of long term care insurance have collecting their benefits. Agents, with the apparent complicity of insurance companies, often misrepresent the benefits and mislead individuals about the circumstances under which the policies will pay. Once an individual files a claim, the insurance companies too often look for excuses to deny the claim. Individuals who file long term care insurance claims are in no condition to take

on the insurance companies. They are elderly, frail and vulnerable. They are dependent on others to care for them.

It is important for all of us to realize that the shortcomings of current private long term care insurance policies result from the inherent limitations of the private insurance market, and not simply from the inexperience of the insurance companies with long term care situations. The shortcomings of current policies -- their high costs and restrictive benefits -- will continue.

The need for long term care benefits differs from our need for other insurance benefits. Unlike the need for automobile insurance benefits or homeowners insurance benefits, long term care insurance benefits are not likely to be needed in any one year, particularly by younger persons. The need for long term care becomes more and more probable as we grow older, and becomes most likely for those 85 and older. It can also be a very costly need.

Those likely to purchase long term care insurance voluntarily are those who foresee a need in the near future. Such adverse selection, combined with the high cost of the benefits, makes decent long term care insurance policies largely unaffordable. Faced with similar inherent limitations of private

acute care health insurance for the elderly, we established Medicare twenty-five years ago.

The inherent limitations of private long term care insurance are described by Robert Ball in his book entitled Because We're All In This Together, published by Families USA Foundation. Bob Ball is known to many of you as an expert on private and social insurance, and as one of the architects of our Social Security system.

As described by Mr. Ball, private insurance is governed by certain ground rules that are necessary because insurers only have access to a limited market. These rules will effectively prevent private insurance from becoming the primary provider of long term care protection for most middle class Americans, let alone for families of more modest means. The three basic rules are:

Rule 1: Insure only manageable risks;
Rule 2: Avoid ambiguous risks; and
Rule 3: Control induced demand.

Rule One leads private insurance companies to protect themselves against adverse selection. This can be done by refusing to insure those with preexisting conditions that might lead to higher than average probabilities of needing long term care, or by selling policies with limited coverage for

preexisting conditions. Rule One makes private insurers hesitant to cover home care, since the need for home care and for specific home care services are difficult to define.

Insurance companies want their obligations to be clearly defined. This can only happen if they follow Rule Two and avoid ambiguous risks. With regard to long term care, this can be done by paying a flat dollar amount for a limited period of time, or by paying only for specific home health services.

Rule Three, control induced demand, discourages private insurers from offering decent home care benefits. Since home care is inherently more desirable than institutional care and since the vast majority of those receiving home care receive it from unpaid family caregivers, home care benefits are likely to be very popular. It is very difficult for private insurers to offer a meaningful benefit, but limit availability at the same time. Government programs are successfully using case management to supplement unpaid caregivers, but private insurance must offer the same benefits to all who pay their premiums and meet the disability criteria.

CONCLUSION

We should not continue to hold much hope that private long term care policies will get better. It is unrealistic to assume that, if we wait long enough, we will be able to leave our long

term care needs in the hands of the private sector. Only by adopting a social insurance approach to long term care, and spreading the risk across the entire population, can we meet our long term care needs in an affordable manner.

We should begin now to build a national system. We should begin enacting the Pepper Commission recommendations. These recommendations are targeted to those of all ages with the most severe disabilities; will make home care much more widely available than currently; and will provide meaningful financial assistance to the majority of Americans needing nursing home care. Families USA will be pleased to work with the Committee to further these recommendations.

Mr. WAXMAN. Thank you very much, Mr. Pollack.
Dr. Davis.

STATEMENT OF KAREN DAVIS

Ms. DAVIS. Thank you, Mr. Chairman, members of the committee, for this opportunity to testify on the great need that exists for expanded financing of home- and community-based services on behalf of the Commonwealth Fund Commission on Elderly People Living Alone.

Improving the financing available for long-term care, including a strong home- and community-based program, is an important first step in making sure that the dignity of disabled Americans is preserved and making sure that they get needed care. We must act now to alleviate the tremendous burden of financing long-term care and the burdens on families of trying to support the disabled.

Last year, the Commonwealth Fund Commission released a report, "Help At Home", that documented the need that many disabled elderly people have for assistance to remain in the community. It set forth a targeted proposal to cover home care services under Medicare that bears many similarities to the Pepper Commission recommendations. I would like to share with you today the major findings of our study and to highlight some of the key features common to both our report and the Pepper Commission's proposal that would help to address the needs of the disabled, facilitate their ability to remain in the community, and enhance the quality of their lives.

Five million elderly Americans suffer some level of physical or cognitive impairment. Of these, 1.6 million of these individuals have limitations that are so severe that they are at serious risk of institutionalization. About a million of those are limited in two or more activities of daily living; another half-million have serious cognitive limitations.

We found that the severely disabled elderly population tend to be disproportionately old, poor, and in worse health. Forty percent of the severely impaired elderly have incomes below the poverty level, and another 40 percent have incomes below twice the poverty level. So we are talking about 80 percent of this population with quite modest incomes. They also have many chronic diseases, such as heart disease, arthritis, and cerebrovascular disease, which means that they have serious needs for physician care, and for hospital care, and for prescription drugs, that can add greatly to their out-of-pocket expenses.

Seven in 10 disabled people receive informal care from family members or friends without any paid help. These caregivers are also extremely burdened. About 35 percent of informal caregivers are over age 65; about a third are themselves in fair or poor health; nearly 1 in 10 had to quit their jobs to be a caregiver; and one-third have incomes below or near the poverty level.

However, we are particularly concerned about the 300,000 elderly who are severely impaired and live alone, without any direct assistance, in their home. This group is particularly in need of formal home care services. Over half rely on such paid services. But they have very limited incomes, tend to be disproportionately poor, and

need financial assistance. So coverage of home care is needed to help these individuals obtain the care and relief of financial burdens.

Therefore, we do support the Pepper Commission's recommendations to have a home care benefit that would be targeted on the most severely disabled. It would help those who cannot manage without such assistance and eliminate the threat of impoverishment. We support the social insurance approach and think it would be helpful to ensure quality standards in this area and assure progressive financing. The Federal Government must take the lead in financing and specifying minimum benefits and eligibility for such a plan.

The principle that we share in common with the Pepper Commission in our recommendation is that services should be targeted on the most vulnerable, the severely disabled. We also support the concept of phasing the plan in over time, starting with those who are most in need. Home care should be stimulated as an alternative to institutionalization. Most people prefer to remain in homes as long as possible, and we should attack that first.

Financing should employ a social insurance approach. We believe that such care would supplement, not displace, families. It would greatly enable families to provide care to this population. Furthermore, we support helping low income populations with out-of-pocket burdens and particularly support the Pepper Commission recommendations to pick up coinsurance for all of those below the poverty level and provide partial assistance for those between 100 and 200 percent of the poverty level.

We congratulate the Pepper Commission for putting forward a thoughtful and much needed long-term care package that would significantly help all disabled Americans if enacted. It provides benefits that are sorely needed and should be phased in as quickly as possible.

I thank you for this opportunity to comment on the importance of long-term care reform for disabled Americans and look forward to working with the committee to make this proposal a reality.

[The prepared statement of Ms. Davis follows:]

PREPARED STATEMENT OF KAREN DAVIS, DIRECTOR, THE COMMONWEALTH FUND, COMMISSION ON ELDERLY PEOPLE LIVING ALONE

Thank you, Mr. Chairman for this opportunity to testify before your committee on the great need that exists for expanded financing of home and community-based services. This is an issue of great importance to the Commonwealth Fund Commission on Elderly People Living Alone. Improving the financing available for long-term care, including a strong home and community-based care program, for people of all ages is an important first step in making sure that the dignity of disabled Americans is preserved and that they do not forego needed care because services are unaffordable or unavailable. Too many of our citizens struggle today with the tremendous burden of financing nursing home care or providing intensive family care at home. They need help now.

Last year, the Commonwealth Fund Commission on Elderly People Living Alone released a major report, entitled Help at Home, that documented the need that many disabled elderly people have for assistance to remain in the community and set forth a targeted proposal to expand the availability of help under the Medicare program. Today, I would like to share with you some of the major findings from our report that compelled us to call for improved financing of home and community services for disabled elderly people. Then I would like to highlight some of the key features common to both our report and the Pepper Commission's proposal that

would help to address the needs of the disabled, facilitate their ability to remain in the community, and enhance the quality of their lives.

Today 5 million of the 29 million elderly Americans who live in the community suffer some level of physical or cognitive disability. For 1.6 million elderly Americans these limitations are so severe that they are at serious risk of losing their ability to remain in the community. About 1 million of these severely disabled people require active daily assistance with 2 or more personal care activities, such as eating, dressing, using the toilet, bathing and transferring from a bed or chair. Within this group, one third also suffer severe cognitive impairment. An additional half million people are able to carry out most basic personal care activities, but struggle with severe cognitive limitations which restrict their ability to live independently without assistance.

The severely disabled elderly population experiences multiple difficulties, but has few resources to draw on for assistance. They are older, poorer, and in worse health than other elderly people:

(1) A quarter of the severely impaired elderly are age 85 or older compared to 8 percent of the total elderly population.

(2) Most of the disabled elderly live on extremely modest incomes—40 percent are poor with incomes less than 100 percent of the Federal poverty level, about $6,000 a year, and an additional 40 percent have incomes between 100 and 200 percent of poverty.

(3) The functional difficulties experienced by the disabled are compounded by poor health. Seventy percent of the disabled elderly are in fair or poor health compared to 32 percent of the total elderly population. The disabled are twice as likely to have heart disease and six times as likely to have cerebrovascular disease than the general elderly population.

(4) The combination of disability and disease within the elderly disabled population results in heavy reliance on medical care. They average twice as many physician contacts and are more likely to have multiple hospital admissions than the nonimpaired. Thus the disabled are likely to be experiencing high out-of-pocket costs for acute care as well as their long-term care needs.

The severely disabled elderly rely heavily on daily assistance from family and friends. Seven in ten disabled people receive all their care without paid help. Providing care to the disabled can be physically, emotionally, and financially draining for the caregivers who are disproportionately women, primarily wives and daughters:

(1) Thirty-five percent are age 65 or older; one-third are themselves in fair or poor health.

(2) Nearly one in ten has had to quit their paying jobs because of caregiving responsibilities. Lack of participation in the formal workplace threatens the future economic security of the caregiver.

(3) Most caregivers are not wealthy. One-third of caregivers have incomes below 150 percent of poverty and most live on modest incomes.

Although the provision of informal care is of vital importance to the severely disabled population, for some, it is not available or not enough. In these cases, formal, paid services are a vital necessity and an important supplement to informal assistance. Thirty percent of severely disabled elderly people living in the community use paid home care services—one-third on a daily basis. Yet, the commitment and generosity of informal caregivers is clearly demonstrated by the fact that most disabled use formal care to supplement that provided by family and friends. Only 5 percent of the disabled elderly rely exclusively on paid services.

Of primary concern to our Commission are the 300,000 severely disabled who live alone in the community. They do not have other household members to call on for assistance and arranging informal care from outside of the household can be extremely difficult, if not impossible. As a result, the severely disabled who live alone are extremely dependent on the receipt of formal services—over half rely on paid services, many on a daily basis. Because they do not have household help, those who live alone are overrepresented among paid care users: composing only 17 percent of the total disabled population, they account for 28 percent of the users of formal care. Given the low-incomes of many of the disabled who live alone, obtaining these services can constitute a severe financial burden.

Currently, there is little formal financing to help the disabled elderly obtain long-term care services in the community. Coverage of home care services under Medicare is restricted to post-acute episodes and does not support the personal care needs of this highly disabled population. Although Medicaid does provide some assistance with long-term care needs, the extent of help is highly variable by state and coverage is limited by stringent income and asset tests. As a result, most community-

based long-term care services are paid for directly by the disabled elderly themselves and their families. Because of their low incomes, few can afford needed help.

Out-of-pocket payments for home care services can be a major financial burden. The cost of an hour of in-home care can range from about $7 to $10 for nonskilled care to over $25 for skilled care. Among those using services, the most severely impaired will spend, on average, $7,800 for services in one year. Those with fewer limitations will still spend substantial amounts ranging from $1,500 to $2,000.

The Commonwealth Fund Commission on Elderly People Living Alone believes that it is important to begin to alleviate some of the heavy financial burden that the severely disabled living in the community face. Providing limited assistance to severely disabled people can make an important difference in the quality of their lives and ability of caregivers to continue to provide for most of their needs. The community care provisions of the Pepper Commission's long-term care reform proposal speak to the gaps in our current delivery and financing system and address the concerns of our Commission.

The Pepper Commission's proposal is targeted to those who are the most severely disabled, regardless of setting. It helps those who cannot manage on a day-to-day basis without assistance and eliminates the threat of impoverishment from the disabled and their families by providing a careful balance of home care assistance and financial support for nursing home care. It recognizes that for those in the community, family and friends are now providing care, but at great physical and emotional cost. In some cases, the burdens are too great and needs go unmet placing the disabled at high risk of institutionalization, functional decline, or other adverse outcomes. In our own deliberations, we felt that the severely disabled must be a priority group for coverage.

The Pepper Commission's proposal calls for social insurance for home and community-based care with a strong role for the Federal government. Our own Commission shares this view. Given the dearth of community services today, it is extremely important to develop the financing to expand the availability of care. Moreover, ensuring the quality of services provided is essential. One of the best safeguards on quality is full participation by families and individuals of all incomes. Progressive financing and benefits on the basis of disability level, not income, are thus essential components of both the Commonwealth Fund and the Pepper Commission proposals. It is imperative that the Federal government take the lead in financing, specifying eligibility criteria and a minimum services package, and assessing the quality of services provided to assure that the system we develop is high quality and accessible to all in need.

Given the low-incomes of most of the disabled elderly population, it is unlikely that private insurance companies will have the inclination or ability to successfully market a long-term care benefit to the people most in need. Medicaid coverage of the disabled population is hampered by complex income and asset eligibility stringent and Medicaid budgets are already strained by the cost of institutional care. The nursing home coverage provisions of the Pepper Commission plan provide universal access to short-stay care and much needed relief from the risk of financial devastation associated with long stays.

There are several key principles that the Commonwealth Fund Commission considered crucial to ensuring that expanded financing of home and community-based services would successfully address the needs of the severely disabled. The Pepper Commission proposal shares many of these same elements. We believe that the following principles are essential in any long-term care reform proposal:

(1) Aid should be targeted to the most vulnerable—the severely disabled. Those people in the community with high levels of physical disability who need active help on a daily basis or severe cognitive disability need help now and should be the first priority for coverage. A comprehensive assessment of functioning and assistance for families in managing care and referral to other services is vital.

(2) Home care should be stimulated as an alternative to institutionalization. The limited availability of home care precludes the ability of disabled people to conduct their lives in the least restrictive environment and places an increasing strain on nursing homes. Disabled people overwhelmingly prefer to remain in the community as long as possible. Expanding the availability and affordability of home care services is crucial to facilitating the ability of disabled to avoid or delay nursing home placement.

(3) Financing should employ a social insurance approach. Assuring that long-term care services are available to all disabled people, regardless of income, is critical to ensuring that all people who need services are served, that financing is sound, and that high levels of quality are maintained.

(4) Care that is already being provided should be supplemented, not replaced. Personal care in the home or extended care in the community can provide an important adjunct to the informal care now provided by family and friends. To strengthen the informal care network, flexibility in service arrangements and scope of care is essential. By providing assistance with help at home, this plan would help to reduce the stress of family caregiving and ease financial burdens for elderly people and their families.

(5) The low-income population should be assisted with out-of-pocket burdens. The low-income disabled living in the community are unlikely to have the ability or resources to purchase private coverage. As a result, they are in serious jeopardy of going without needed care because the cost of care is out-of-reach or incurring financial burdens that result in impoverishment. A public long-term care plan is necessary to help meet their needs. In addition, it is vital that special protection be provided for the low-income population against burdensome cost-sharing requirements.

In summary, the Pepper Commission has put forward a thoughtful and much needed long-term care package that would significantly help all disabled Americans if enacted. It provides benefits that are sorely needed and should be phased in as quickly as possible. Preserving the dignity and independence of the disabled population is an important societal goal. Assuring that the disabled are not required to undergo severe economic hardship to obtain help with basic needs is well within our society's resources and an essential priority for policy action.

Thank you for this opportunity to comment on the importance of long-term care reform for disabled Americans. I look forward to working with the Committee to make this proposal a reality for the disabled and their families.

Mr. WAXMAN. Thank you very much, Dr. Davis.

Mr. McConnell.

STATEMENT OF STEPHEN McCONNELL

Mr. MCCONNELL. Thank you, Mr. Chairman and members of the committee.

On behalf of the Alzheimer's Association, I am pleased to be here to address one of the most important subjects facing Americans today. Alzheimer's is the quintessential long-term care problem. If we can solve the problem for Alzheimer's victims, we can design a system that will help most other people with chronic illnesses.

Alzheimer's is a horrible degenerative disease. It robs people of their memory, their judgment, and ultimately their dignity. Half of us in this room, if we live beyond the age of 85, will suffer from Alzheimer's disease.

The care system today leaves a lot to be desired. On the home care front, 70 to 80 percent of Alzheimer's patients are cared for at home by family members and friends. The average age of those family members is 62.8, and yet 20 percent of Alzheimer's victims live alone.

In an informal survey we did of 53 family members, we found that half of those family members had cared for someone at home for 7 or more years, a quarter for 10 or more years at home, most of them without help.

We support the Pepper Commission recommendations to provide social insurance protection for people at home. It is the most important first step. When we posed the question to the question to volunteers in the organization if they had to choose between nursing home coverage or home care protection, by a margin of two to one, they said the first thing we should do is provide home care protection.

Mr. Chairman, our association also enthusiastically supports the Medicaid Home and Community Care Amendments that you are

sponsoring, and we are working very hard to help get those enacted this year.

On the nursing home side, Alzheimer's patients are different than most other chronically ill people. Alzheimer's patients tend to stay in nursing homes for a long time. Again in this informal survey, we found that 60 percent of the family members reported that their loved ones had been in a nursing home for 4 or more years. For example, one father and son reported that they had cared for their mother for 12 years—10 years in a nursing home—at a cost to their family of $200,000.

We support the Pepper Commission recommendations on long-term nursing home coverage. The asset and income protections provided by that benefit would substantially improve the situation for most of our families. We recognize the need to hold down the cost of this program, and while we support a social insurance program we feel that the long-term protections are a very important first step.

On the 3 months social insurance protection, that won't do a lot for Alzheimer's families, because the patients tend to stay in nursing homes so long. On the other hand, having that available should help people gain access to a nursing home, which could be very important in the long term.

A few other comments about the Pepper Commission recommendations. On the eligibility requirements, the coverage for the cognitively impaired is very important. Traditionally, we use activities of daily living measurements, and those leave out most cognitively impaired. For Alzheimer's patients, long before all physical capability is lost, memory and judgment are so impaired that a person needs to be verbally reminded, physically cued, and supervised. Otherwise, they can't perform many physical tasks. So if we just have an ADL requirement, it doesn't pick up the needs of most Alzheimer's patients. We commend the Commission for recognizing the need to cover the cognitively impaired.

One final item. On the issue of phasing in, again, we think that it is important to phase in this program because we need to build the infrastructure; we need to put the program in place, and that is going to take some time. Respite care is a good place to start, but the current respite benefit that is being considered by Congress, as it is currently structured, will not help those that it is designed to help. For one thing, it requires that a person meet a strict ADL test. It does not recognize the need for supervision, for cuing, and for verbal reminding. Therefore, people with Alzheimer's disease would not necessarily qualify for that benefit. Second, and more importantly, that benefit requires that people have very high out-of-pocket expenditures in order to qualify. Alzheimer's victims don't have high medical costs; there isn't much that medicine can do for an Alzheimer's victim, so they won't qualify under that limit. Therefore, when people talk about a respite benefit and how much good it is going to do for Alzheimer's patients, that benefit won't help them.

Mr. Chairman, I would like to submit just a very brief statement that outlines in more detail the criticisms of that respite benefit.

In conclusion, despite its gaps, the Pepper Commission plans would substantially improve the lives of Alzheimer's patients and

families. Home- and community-based care, long-term nursing home care, and improved standards for care would be a welcome relief to those now struggling to survive this nightmare on their own.

The Alzheimer's Association wishes to commend you, Mr. Chairman, your colleagues on this subcommittee, and the members of the Pepper Commission who supported the long-term care recommendations, for your dedication to solving the number one health problem in America.

[Testimony resumes on p. 68.]

[The prepared statement and criticisms of respite benefit of Mr. McConnell follow:]

THE IMPACT OF THE PEPPER COMMISSION RECOMMENDATIONS ON THE LONG TERM CARE NEEDS OF ALZHEIMER PATIENTS AND FAMILIES

Stephen McConnell, VP for Public Policy
Alzheimer's Association
June 14, 1990

Mr. Chairman, distinguished members of the Subcommittee, I am pleased to join you and my colleagues from other prominent advocacy organizations to discuss one of the most important subjects facing American families today.

Few of us will escape the clutches of long term, chronic illnesses. And, few of us will be able to cope with the problem when it strikes -- unless we move now to enact a comprehensive long term care program.

Alzheimer's disease[1] is the quintessential long term care problem. If we can solve the needs of Alzheimer patients and families, we will have produced a system that should work well for all others with chronic, incurable illnesses.

Alzheimer's Disease -- The Scope of the Problem

Alzheimer's disease is a horrible degenerative disease that robs its victim of memory, judgement, dignity -- everything that makes that person a unique human being. It is irreversible, untreatable, and inevitably fatal.

The disease claims 4 million Americans today. It can strike adults at any age, but its likelihood increases dramatically with age. Roughly 10% of the population over 65 years of age has probable Alzheimer's. Half of us in this hearing room who reach the age of 85 will spend the last years of our lives as victims of this terrible disease.

Alzheimer's does not strike suddenly, and the end is rarely quick. From the onset of symptoms, a person can live anywhere from 2 to 20 years -- sometimes even longer. In every case, he or she

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[1]When reference is made to "Alzheimer's disease," it is meant to include the "related disorders" as well.

will eventually need constant supervision and assistance to carry out the most basic functions of daily living.

Alzheimer's disease is the "worst case" example of the need for long term care in this country.

The Care System Today

The emotional and financial burden of care overwhelms the family of an Alzheimer patient. All of the agony of watching a loved one disappear before their eyes is compounded by public policy that says -- "You're on your own."

Home and Community Care. Most Alzheimer patients -- at least 70 to 80% -- stay in the community, where informal caregivers provide most of the supervision and assistance they need. The majority of these caregivers are spouses -- some are physically frail and confused themselves. One-third are adult children. A few are siblings or friends. According to one study, the average age of these caregivers is 62.8 years.

One-third of the adult children who have primary responsibility for care are also trying to work, at least part-time. Many are dividing their time, their money, and their emotions between frail parents and their own children.

Perhaps the most alarming aspect of this informal care system is that it leaves as many as 20% of all Alzheimer patients living alone.

To gain some insight on these statistics, the Association conducted an informal survey of 53 volunteers who were attending its Board meeting in January, 1990. All of them were or had been caregivers of an Alzheimer patient. Nearly half had provided care at home for 7 or more years (and many are still providing care at home). Thirteen reported providing home care for 10 or more years. Fourteen kept their loved one at home through the entire illness. Most did so without benefit of outside help.

Caring for an Alzheimer patient at home is expensive. For those who hire help, the cost is prohibitive. In our survey, one caregiver reported keeping his spouse at home for 11 years and "in the later years" paying for home care at $30,000 per year. Another paid a total of $81,000 during the 8 years of caregiving at home.

Even when the family caregiver is not working and provides full-time care himself or herself, a family can easily spend $5000 to $6000 for care supplies and occasional help. Just the cost of diapers can amount to $60 a week.

Take, for example, the case of a 65 year old woman in suburban Detroit whose husband has had Alzheimer's for 18 years. For the past 7 years, he has been bedridden and incontinent. They live on his pension and she provides full time care. Even so, she has to hire someone for two hours a day, to help lift her husband from the bed to a wheelchair, watch him while she runs to the grocery store and does other essential errands, and then help her get him back to bed. The cost of this minimal care is nearly $3000 a year. The supplies she uses to manage his incontinence amount to more than $2000 a year.

None of these costs is covered by Medicare. These are not medical services, they are not medical supplies. Even the proposed Medicare respite benefit would do nothing to help because it is contingent on high out-of-pocket medical expenses, which are not the kind of costs most Alzheimer patients do incur.

Medicaid may provide some help, in states that operate a 2176 waiver program or cover some personal care services under their state plan. That could be expanded with enactment of the Wyden-Waxman Medicaid Home and Community Care Amendments -- which the Association supports enthusiastically. But these services are limited to persons with the very lowest income and they are threatened by the fiscal problems many states now face.

Nursing Home Care. Even though most Alzheimer patients are at home, persons with Alzheimer's disease and related disorders are a large portion of the nursing home population. Data from the 1985 National Nursing Home Survey indicate that nearly half of all elderly residents have dementia and nearly two-thirds are so disoriented or memory impaired that they have difficulty every day in performing ADLs, mobility and other tasks.

The typical cost of a year in a nursing home ranges from $25,000 to $36,000 for our families. They get no help paying the bill, until they have spent down to the eligibility limits that qualify them for Medicaid. While data suggests that a majority of nursing home residents never reach that stage of impoverishment, Alzheimer's patients are the ones that do -- because they typically stay in a nursing home for a relatively long time.

Our survey of volunteers in January found that only 13 percent of Alzheimer patients who were placed in nursing homes had stays of a year of less before they died. Sixty percent had been residents for more than four years. The following examples are fairly typical:

- A father and son cared for their spouse/mother for 12 years. For two of those years she was at home. The next 10 were spent in a nursing home at a cost to the family of $200,000.

- After 10 years of home care, Mrs. A placed her husband in a nursing home where he has been for four years. The cost: $36,000 per year.

- Mr. B placed his wife in a nursing home 9 years ago. To date, he has spent $200,000 on her care.

Special Needs of Alzheimer Caregivers

Every time Alzheimer's strikes, it claims at least two victims -- the patient and the family caregiver.

Family members caring for Alzheimer patients are enormously dedicated, motivated by love, commitment and responsibility. The Association itself exists because these family members have reached out beyond their own caregiving situation to support each other and to advocate for public policy that will make things easier for people who will face this nightmare in the future.

But, as studies conducted through the National Institute of Mental Health are discovering, caring for an Alzheimer patient has a negative impact on the caregiver that is far greater than for caregivers of elderly persons in general.

These negative consequences of caregiving include subjective feelings of burden, depression, increased use of alcohol and psychotropic drugs, and reduced participation in social activities. New NIMH studies are documenting adverse effects on the immune and cardiovascular systems of caregivers which persist long after the caregiving burden is over.

It is not hard to understand why this happens. When Alzheimer's strikes, it takes the very essence of the person and leaves behind an empty shell -- one that often remains physically healthy well into the course of the disease. That in itself is hard enough to bear. But with the loss of memory and judgement and self awareness comes a host of practical problems. Some of them are difficult to manage physically -- dressing an uncooperative adult is even harder than trying to get a shirt on a restless toddler. But those are the relatively easy ones. It is the constant agitation, the incessant pacing, wandering, sleeplessness, hallucinations and suspicions, the dangerous behavior that means the caregiver can never get away from the constant demands. The final indignity, incontinence, is often the crowning blow.

The disease leaves the family without hope. The government leaves the family without help.

36-343 0 - 90 - 3

How the Pepper Commission Recommendations Will Help

The Pepper Commission has advanced the cause of long term care immeasurably by defining the scope and cost of the problem, acknowledging that long term care affects all ages, and offering a modest package of publicly funded benefits that build on a social insurance model.

The Alzheimer's Association, with AARP and Families USA, is one of the lead organizations in the Long Term Care Campaign and, as such, is firmly committed to a comprehensive long term care social insurance program for persons of all ages.

The Commission's proposal is an important step toward that ultimate goal. And for the first time, it would provide meaningful help to Alzheimer patients and families.

1. Home and community care. The first priority for families struggling with Alzheimer's disease is coping with care in the home. Thus, the universal social insurance program for home and community based care is the most important component of the Commission's proposal. Because most Alzheimer patients are at home, and because they require constant care and supervision, the respite benefits, homemaker chore services and training for family members will be invaluable to Alzheimer patients and families.

During the Pepper Commission's considerations, we posed a question to volunteers in the Association, nearly all of whom are or have been caregivers: "If the government has to choose between providing home care or nursing home care as the first step in long term care services, which would you prefer?" By a two-to-one margin, the caregivers preferred home care.

2. Nursing Home Coverage

a. Long Term Coverage. Because Alzheimer patients typically remain in nursing homes (or board and care homes) for long periods of time, the Commission's proposals for long term nursing home care are particularly important for our families. The Commission's plan to provide unlimited, long term nursing home care to couples who have $60,000 or less in non-housing assets would help ensure access to care and protect families from bankruptcy. The reasonable income protection (200% of poverty) and housing allowance (30% of monthly income) are also vast improvements over the current Medicaid system.

The nursing home protection for single persons, while based on an understandable rationale, is less clear in its impact on Alzheimer patients. We are concerned about the tighter asset and income provisions for the one in five Alzheimer victims who lives

alone. These individuals are likely to enter a nursing home sooner and remain longer than others because there is no one in the community to care for them. Some may return periodically to the community. If their assets are depleted and they have not been able to keep adequate income, their options will also be seriously limited. We hope the eventual program enacted can accommodate their needs.

b. Three Month "Front-End" Coverage. For the vast majority of Alzheimer patients, three months protection for nursing home stays is only marginally useful as a long term care benefit. It may, however, ensure better access to facilities for our patients (who often have unique care needs) by guaranteeing social insurance payments that are not linked to income/asset requirements. We strongly support social insurance protection for long nursing home stays and would hope there might be some way to extend the three month coverage substantially. We do, however, understand the budget constraints which necessitate limiting expenditures at this time.

3. Eligibility Requirements. We are heartened by informal discussions with Commission members and staff about the eligibility requirements that will be included in the final recommendations. We appreciate the need, in a tight budget situation, to limit access to those with the most severe functional disabilities. Such limitations, however, cannot be based solely on tests that measure a person's physical ability to perform Activities of Daily Living.

As you, Mr. Chairman, have recognized in your own Eldercare, Long Term Care Assistance legislation, and in the Medicaid Frail Elderly amendments you are cosponsoring with Mr. Wyden, eligibility language must specifically recognize the nature of the functional disability caused by a cognitive impairment like Alzheimer's disease.

Long before an Alzheimer patient loses the physical capacity to function, the disease so impairs that person's memory, judgement and decision-making capacity that he or she can no longer perform even routine activities of daily living without being verbally reminded, physically cued, and/or supervised. And it is often in these earlier stages of the disease, while the patient is still physically active and healthy that he or she needs constant supervision because of behaviors that risk the health and safety of self or others -- he wanders away from the house and has no idea where he is, She cannot recognize her own limitations, and can no longer remember how to call for help. He turns on the gas burner and forgets about it. A definition of eligibility based on a narrow ADL test of physical ability would leave most Alzheimer patients outside the system.

4. Administrative Issues. Without more details about the various administrative recommendations, it is difficult to offer constructive comment. The concept of building on existing service delivery structures, maintaining state and local control, uniform assessment and certification standards and improved provider payment rates are laudable goals.

On the issue of care coordination, we encourage you to take extra precautions to ensure that the autonomy and decision-making of patient and family members is not infringed. Care coordination should be designed to ensure that the best and most appropriate care is provided. Often it is the family member or the patient himself who knows best what is needed. If care coordination places an inordinate emphasis on cost containment, quality of care could be jeopardized.

The idea of phasing-in the program is an excellent idea, both to ensure the infrastructure of services is in place and to avoid immediate budgetary problems. We would hope that the phase-in would begin with home and community-based services. More importantly, we hope you will avoid the problem we now face with legislation moving through Congress to reinstate the so-called respite benefit that was first enacted with the Medicare Catastrophic law. Because eligibility is so closely linked to acute care expenditures and traditional "activities of daily living" (ADL) measures, this benefit would be unavailable to virtually all Alzheimer families, thereby depriving those most in need of this vital service. (I have a further statement about the problem with the proposed respite benefit which I would like to submit for the Record.)

5. Program design. On the surface, the long term care needs of the person with Alzheimer's disease or a related disorder look much like the needs of the physically disabled. They need diagnosis and assessment, personal care and companion services, respite and adult day care. At some point in the disease, many will need nursing home services.

But the cognitive nature of the disability changes the design of the services the Alzheimer patient needs. This Subcommittee has recognized the special care needs of Alzheimer's patients and has taken leadership in trying to address them -- through such initiatives as the OBRA requirements for special training of nurse aides and the Medicaid Frail Elderly Amendments.

The Office of Technology Assessment is about to release a major study of services for Alzheimer patients which underscores the importance of designing a long term care system that can take into account the particular needs of these patients and families. Their findings are consistent with the daily experience of the family members and caregivers who make up the Association.

1. Alzheimer patients need certain types of services more often than other disabled persons -- personal care, home-delivered meals, respite care, and homemaker services.

2. Services have to be modified to meet the particular needs of Alzheimer patients. For example, transportation services will not work, unless an escort and companion is provided to keep the patient from getting lost or forgetting why he left home.

3. Working with an Alzheimer patient takes more time and effort than working with other clients. That means more special training. It may also mean added costs.

4. Because the needs of the Alzheimer patient are so variable and interrelated, providers must have substantial flexibility to meet those needs.

Conclusion

Despite gaps in the proposal, the lives of Alzheimer patients and families will be much improved if Congress enacts the Pepper Commission recommendations. The availability of home and community based care, long term nursing home care, and improved standards for care will be a welcome relief to those who are now struggling to survive this nightmare on their own.

The Alzheimer's Association wishes to commend you, Mr. Waxman, your colleagues on this Subcommittee, and the members of the Pepper Commission who supported the long term care recommendations, for your dedication to solving the number one health problem in America.

PROPOSED MEDICARE RESPITE BENEFITS IN H.R.3880 AND S.2246 WILL NOT BE AVAILABLE TO MOST CHRONICALLY DEPENDENT MEDICARE BENEFICIARIES, INCLUDING ALZHEIMER'S VICTIMS

Organizations and Members of Congress interested in respite care should be aware of pitfalls in the Medicare Improvements Act of 1990 (H.R.3880 and S.2246) that will effectively deny the respite benefit to most of the chronically dependent elderly who need such assistance.

Supporters of respite care commonly use Alzheimer patients and those suffering from similar disorders to "make the case" for such care. Families caring for Alzheimer patients repeatedly cite respite care as the single most important service they need. Yet the bill is written in a way that excludes these very patients from the respite benefit it purports to provide.

If the bill is enacted in its present form, Congress will be asking Medicare beneficiaries to pay for a benefit that those who need it most will not be able to receive.

The pitfalls occur primarily because, in an attempt to limit cost (and thus the size of the part B premium increase required to finance the benefit), the bill was intentionally written to restrict access to a small subgroup of the most seriously ill Medicare beneficiaries. While such persons have critical needs for medical care and services including home health care (and receive some Medicare reimbursement for such services), they are not typical of the chronically dependent Medicare beneficiary who needs respite care.

To be eligible for the respite benefit, a Medicare beneficiary would have to meet two tests which combine to rule out most of the chronically dependent elderly:

1. The beneficiary must be among the 5.5 percent of all Medicare enrolles who incur the highest yearly out-of-pocket part B medical expenditures, and

2. The beneficiary must be dependent on a daily basis in the performance of at least 2 of 5 activities of daily living (ADLs).

While further analysis may be needed to determine exactly who would meet this cost-sharing test, the language effectively rules out all but those who have very high medical bills, i.e. persons who have had an acute and costly medical crisis during the year or who have a chronic disease that requires expensive skilled medical care.

The out-of-pocket cost of caring for a chronically dependent individual at home is substantial. It can easily reach $15,000 a year or more for an Alzheimer patient. Few if any of these costs would count, however, against the cost-sharing requirement of the proposed legislation.

While the cost-sharing requirement will exclude most chronically dependent Medicare beneficiaries, a substantial number would be doubly excluded by the second "gate" to service, the ADL test. The bill does not specify that the need for assistance include the need for supervision, physical cueing, or verbal reminding (the type of ADL assistance that many chronically dependent individuals need), nor does it include the need for supervision because of behaviors that pose serious risk to health and safety (the other essential indicator of need for dementia patients and many others).

A narrow ADL test will rule out large numbers of Medicare beneficiaries, including Alzheimer patients, who are dependent on round-the-clock care from family caregivers. Arguably, full-time caregiving of patients who would meet the alternative tests noted above is even more demanding and stressful than the care of the physically disabled and creates an even greater need for respite services.

There are a number of other provisions in the bill that have the effect of limiting respite services, including

* a cap of 80 hours of respite care a year (to be used in segments of at least 3 hours a day, thereby limiting services effectively to a maximum of 27 days)

* a restriction to services provided in the beneficiary's home, eliminating two of the three forms of respite care (adult day care and short-term institutional care)

* a requirement that the primary caregiver live in the home of the beneficiary and provide care without reimbursement.

Although each of these provisions has the effect of limiting respite services, arguably they are reasonable (though highly restrictive) ways to make choices to provide a limited respite benefit which could be expanded as resources become available. These provisions are far less objectionable, in the context of a first step, than eligibility language that has the effect of excluding the very people the legislation purports to serve.

(prepared by Alzheimer's Association, 1334 G Street NW, Suite 500, Washington, DC 20005; 202-393-7737)

Mr. WAXMAN. Thank you very much, Mr. McConnell.

Let me start my questions with Mr. Rendish.

I share the AARP's goal of establishing a social insurance type of long-term care program. In fact, I introduced legislation to do just that.

But, as the debate within the Pepper Commission clearly showed, a social insurance type of program may not be politically or financially possible in the near future. I voted for the Pepper plan despite my own preference for a social insurance type of program because it would clearly be a vast improvement over the current system.

In arguing for a comprehensive social insurance scheme, do you mean to suggest that the Congress should not move forward with any long-term care plan that provides less than that type of coverage?

Mr. RENDISH. Yes, Mr. Chairman. The association supports a comprehensive, total reform of our health care system, and this was acknowledged by one of the Congressmen earlier today in his opening statement.

We commend the Pepper Commission for all its recommendations, but we cannot take a supportive position for any specific proposal at this time.

Mr. WAXMAN. So unless you had the perfect proposal you wouldn't support a good proposal?

Mr. RENDISH. No. What we need first, before we can make a commitment, is a financial assessment of what it is going to cost. Then we also have to know if there is anything in the reform measure that is going to affect cost containment.

Mr. WAXMAN. So, in other words, if you are going to go for anything more limited, you want more information about it?

Mr. RENDISH. Yes.

Mr. WAXMAN. You are not closing the door on something.

Mr. RENDISH. Absolutely not.

Mr. WAXMAN. Okay. I want to address my next question to the entire panel.

AARP suggests in its testimony that our first long-term care reform priority ought to be protection against high nursing home costs. But later, we are going to hear from the American Association of the Homes for the Aging—an organization which represents nursing homes—which suggests its written testimony that many people are, in fact, becoming impoverished because of the high costs of community care.

Wouldn't that point argue for making coverage of home care services the first priority towards the establishment of a comprehensive long-term care package?

Dr. Davis, why don't we get your reaction to that.

Ms. DAVIS. I think that is a very good point. Our study found that, in fact, those who are at home and severely impaired already are quite low income. Forty percent are below the poverty level; another 40 percent have incomes below twice the poverty level.

We also at the Commonwealth Fund Commission funded a study to look at poverty among widows and found that half of widows were not poor when their husbands were still alive. They were driven into poverty by the expenses associated with his death; long-

term care expenses, medical expenses, and others, as well as loss of income.

So I think getting in earlier, trying to provide some assistance to the population in the home, should be a top priority.

Mr. WAXMAN. Mr. McConnell, what are your views? Should our top priority be nursing home assistance, or should our top priority be community home health care?

Mr. MCCONNELL. The top priority, if we can't do it all, is to start with home care. Home care is costing families a tremendous amount. If the caregiver has to work, he or she has to bring in someone to care for the patient. One example in this little survey we did was, a family spent $81,000 over an 8-year period to help care for a patient.

But even if they don't work, there are still problems. Take the example of a 65-year-old woman, a suburban Detroit woman, whose husband has had Alzheimer's for 18 years. For the past 7 years, he has been bedridden and incontinent. They live on his pension. She provides the care, but in order to get him out of the bed and into a wheelchair, in order to get out and do some shopping, it costs her $3,000 a year, just for that little bit of service.

Mr. WAXMAN. Let me cut you off, unfortunately, because I just want to get a quick response. I have other questions and limited time.

Mr. Pollack, what is our highest priority, home care or nursing home care?

Mr. POLLACK. I would say home care, quite definitely. We don't have an infrastructure right now for home care. If you ask people what is their preference in terms of where they want to be if they have a disability, they want to stay in the home and in the community. But currently, our incentives are towards institutionalization. We have to neutralize that incentive.

Mr. WAXMAN. My next question is for the entire panel.

The nursing home part of the Pepper plan provides protections of assets of up to $60,000 for those who have to stay in a nursing home for a longer period of time than the first 3 months.

The plan is not, however, a social insurance program. There is a spend-down to a more generous amount than we now have in Medicaid.

Doesn't this program go a long way in protecting people against the indignity of impoverishment? Doesn't it go a long way in protecting people's standard of living? Doesn't it move us away from a welfare-based program? Doesn't it go a long way toward reaching the goals that we strive for under a social insurance model? And if all those things are true, would you support that kind of a plan, even though it is not a complete social insurance protection plan?

Mr. McConnell, we will start with you.

Mr. MCCONNELL. To make up for my longer answer earlier, yes.

Mr. WAXMAN. Thank you.

Ms. DAVIS. I think social insurance has a lot of advantages, and I strongly support that for home care.

In the case of the asset and income protection, I think you ought to look at it as a major improvement over the existing Medicaid program, which certainly wipes out the assets of impaired people. It doesn't give them very much in the way of a personal needs al-

lowance—$25; the Pepper Commission allows $100. The plan would protect 30 percent of income for the first year and permanently for a spouse. So I think if you look at it relative to Medicaid—even given the improvements made with the spousal impoverishment provisions in the catastrophic bill that were not repealed—the plan would be an improvement over what we have now.

Mr. WAXMAN. Mr. Pollack.

Mr. POLLACK. The answer is yes. The reason is that I think you have struck a decent balance between proper access and protection for people in nursing homes and for spouses as well as for people who might be coming home. On the other hand, you had to balance that with asset protection, which is a lower priority.

Mr. WAXMAN. Mr. Rendish.

Mr. RENDISH. We could support that proposal, but we still cling to social insurance for all nursing home services.

Mr. WAXMAN. Okay.

Thank you all very much.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Rendish, you state that public surveys indicate that Americans view health care as a right and that the public supports extending coverage to all uninsured people. Do these surveys also address paying for these services, and are these same Americans willing to pay increased taxes to cover the cost of these services?

Mr. RENDISH. Yes, the association has performed many surveys, and other organizations have also conducted surveys. I have one here that I would be willing to give to the committee that was performed just recently by the Fair Share organization.

Mr. BLILEY. I am sure the chairman will make it a part of the record.

Mr. WAXMAN. We would be pleased, without objection, to make that a part of the record if you would submit it to us.

[The survey follows:]

Washington Fair Share
January 20, 1990
Frequency Questionnaire

SAMPLE A B

GREENBERG-LAKE:
THE ANALYSIS GROUP, INC.
515 2ND Street, N.E.
Washington, D.C. 20002

550 PERSONS

Hello. This is (caller name). I'm calling for Washington Opinion Surveys. I would like to ask you a few questions concerning the problems facing our state and local communities.

We need a balance of men and women in this survey. May I speak to the youngest man, 18 years or older, who is at home right now?

(If respondent, continue to Q1).

If yes, repeat introduction for new respondent and continue.

If no male
Okay, may I speak to the youngest woman, 18 years or older, who is at home right now?

Repeat introduction or continue with interview

1. First of all, are you registered to vote in Washington?

If yes, continue with Q 2
If no: I'm sorry. Is there a registered voter at home I can speak to?

Repeat introduction or terminate

2. Which of the following do you agree with most: [READ LIST AND NUMBER]

1. On the whole, the health care system in Washington state works pretty well and only minor changes are necessary 18

2. There are some good things about the health care system in Washington state, but significant changes are needed.....53

or

3. Washington state's health care system is so inadequate and has so many problems we need to completely overhaul it.....22

4. Don't know [Don't read].....6

3. What personally bothers you the most about health care? [READ LIST AND ROTATE RESPONSES]

rising health care costs.....46
people not having insurance.....18
fear of catastrophic illness.....11
cost and red tape of insurance.....14
or inability to get the best health care treatment.....8
other (volunteered).....2
don't know (volunteered).....1

4. What is most important to you in the health care system?

[READ LIST AND ROTATE]
less insurance paperwork.....2
choice of doctors.....12
immediate access to non-essential health care.....3
choice of insurance companies.....2
holding down cost increases.....33
access to the newest technology.....6
or insurance coverage for everyone.....42
other (volunteered).....1
don't know (volunteered).....1

5. What is the next most important?

[READ LIST AND ROTATE -- DO NOT READ RESPONSE FROM Q7]
less insurance paperwork.....9
choice of doctors.....14
immediate access to non-essential health care.....6
choice of insurance companies.....4
holding down cost increases.....33
access to the newest technology.....11
or insurance coverage for everyone.....20
other (volunteered).....0
don't know (volunteered).....3

Now let me describe to you a proposal for changes in Washington state's health care system and I want you to tell me whether you strongly favor, favor, oppose, or strongly oppose this system.

The Braddock plan, patterned after the Canadian health care system would replace the current multiple insurance systems paying for health care with a single, comprehensive health insurance plan run by state government. The plan would guarantee health care coverage for every resident in Washington state. State government would negotiate prices with doctors and hospitals for basic health care services. Individuals would still choose their own doctor and hospitals. The plan would be paid for by a combination of existing funds like Medicare, fees paid by users, premiums paid by businesses, and taxes which would result in lower over all health care payments for state residents. [REPEAT IF NECESSARY]

6. Do you strongly favor, favor, oppose, or strongly oppose this plan? [IF UNDECIDED: Well, which way would lean?]

strongly favor (go to Q7)	24
favor (go to Q7)	43
oppose (go to Q8)	19
strongly oppose (go to Q8)	11
don't know (volunteered)(go to Q9)	3

[ASK ONLY THOSE WHO FAVOR IN Q6]

7. What was the most important reason you favored the Braddock Plan?

[READ LIST AND ROTATE]

	guaranteed health coverage for every resident	61
	cost controls on doctors and hospitals	21
	a single, simpler payment system	1
	the ability to choose your own doctor	5
	using the Canadian model	5
	less red tape and paperwork	4
or	eliminating the need for private insurance for most health care	4
	other (volunteered)	0
	don't know (volunteered)	0

[ASK ONLY THOSE WHO OPPOSE IN Q6]

8. What was the most important reason you opposed the Braddock Plan?

[READ LIST AND ROTATE]

	a state run system instead of private insurers	41
	government cost controls over doctors	8
	higher taxes	13
	fees paid by users	5
	reduced quality of care	17
or	reduced choice in health care	7
	other (volunteered)	8
	don't know (volunteered)	2

Now I am going to read you two statements that people have made about the Braddock health care plan and I want to know which you agree with more.

Supporters say the Braddock plan would provide quality health care for every resident in Washington state, reduce health care costs by cutting insurance costs and negotiating prices, and still permit individuals to choose their own doctors.

Opponents say the Braddock plan which is run by state government would elminate people's choice, end up costing more, result in long waits and less access to health care, and reduce access to high quality health care provided by the private sector.

9. Which do you agree with more -- the opponents or the supporters? If you are not sure, tell me which way you would lean if you had to decide today.

Supporters	61
Opponents	32
both (volunteered)	2
neither (volunteered)	2
don't know (volunteered)	4

SPLIT SAMPLE A

Now, please tell me whether you agree or disagree with the following statements. If you agree or disagree strongly, please say so.

ROTATE Q10-Q12

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
10. Every person in Washington state is entitled to basic health care coverage. Do you strongly agree, agree, disagree, or strongly disagree?	48	40	9	2	0
11. Health care costs are so out of control that we will have to have a government health care system.	25	41	24	7	2
12. Private industry will keep health care costs cheaper than any system run by state government even if there are cost controls.	7	26	50	12	5

GO TO Q16

SPLIT SAMPLE B

Now, please tell me whether you agree or disagree with the following statements. If you agree or disagree strongly, please say so.

ROTATE Q13-Q15

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
13. We should guarantee basic health care for everyone in Washington state, even if it means an increase in taxes. Do you strongly agree, agree, disagree, or strongly disagree?	26	42	22	9	1
14. There is too much paperwork, and insurance companies make too much profit in health care.	34	40	18	2	6
15. We cannot afford to have state government provide quality health care for everyone in Washington state.	9	28	44	17	2

Finally, I would like to ask you a few questions for statistical purposes.

16. Generally speaking, do you think of yourself as a Republican, a Democrat or what?

(If Democrat) Would you call yourself a strong Democrat or a not very strong Democrat?

(If Independent) Do you think of yourself as closer to the Republican or Democratic Party?

(If Republican) Would you call yourself a strong Republican or not very strong Republican?

Strong Democrat 19
Not strong Democrat 17
Independent - lean Dem 10
Independent.....9
Independent - lean Rep.....11
Not strong Republican 21
Strong Republican.....13
other (volunteered).....1
don't know/refuse (volunteered).....1

17. What is your age?

(Read)
Under 25.....8
25-30 5
31-36 16
37-45 23
46-60 23
over 60.....24
refused/don't know (DO NO READ).....0

18. Are you married, single, separated, widowed, or divorced?

married.....74
single.....14
separated/widowed/divorced...12
don't know (volunteered).....3

19. (If married male) Does your wife work outside the home or would you say that her work is mainly at home?

employed.....(GO TO Q21).....47
at home.....(GO TO Q21).....53
don't know (volunteered).(GO TO Q 21).0

20. (If female respondent) Do you have a paid job outside your home or would you say that your work is mainly at home?

employed.....54
at home.....43
don't know (volunteered).....3

21. Have you or has any member of your family gone without necessary health care because it was too expensive or you were not insured?

yes.....21
no.....79
don't know (volunteered).....0
refused 0

22. Do you pay the whole cost of your own health care, is it fully paid for by your employer, is it partially paid for by your employer, or is it provided by some public program like Medicare?

pay own.....17
fully paid employer.....20
partially paid employer.....45
public program.....12
other [volunteered].....4
don't know [volunteered].....1
refused 0

23. What kind of health care do you use: an insurance plan which lets you choose any doctor, an insurance plan with a limited choice of doctors or a PPO, an HMO like group health, or a public clinic?

private doctor.....58
PPO.....15
HMO.....20
public clinic.....2
don't know (volunteered).....2
other (please specify).....2

no insurance 0
refused 1

24. In the last five years have you personally had any major medical problem or has someone in your family had a major medical problem?

yes, self.....26
yes, family member.....26
no problems.....48
don't know (volunteered).....0
refused 0

25. Would you please tell me into which of the following categories the total yearly income of your household falls -- including every one in the household?

(READ)
under $10,000.....3
$10,000-$15,000.....6
$15,000-$20,000.....7
$20,000-$25,000.....9
$25,000-$35,000.....20
$35,000-$45,000.....13
$45,000-$50,000.....10
over $50,000 22
retired.....4
refused/don't know
(don't read).....7

THANK YOU VERY MUCH FOR YOUR TIME (TERMINATE)

Mr. RENDISH. The surveys show that the American public is willing to support as much as $50 a month to help pay for health care reform.

Mr. BLILEY. I appreciate that. The only thing that bothers me is that last year we were lobbied rather heavily by your members to repeal the fees on catastrophic health care that were currently in the law at that time.

Mr. RENDISH. Yes. The catastrophic care bill was never intended to deal with the long-term health care problem. I think it is two different pieces of legislation, Congressman.

Mr. BLILEY. Okay.

Mr. Pollack, currently the only way States can make available home- and community-based services is through a section 2176 or 1915(d) waiver. How would you recommend changing the system to make home- and community-based services more widely available?

Mr. POLLACK. In effect, you are asking what can we do as an interim step before we give more serious consideration of the full proposals by the Pepper Commission.

I think one very good first step would be to enact H.R. 3933 that is cosponsored by the chairman and Mr. Wyden. I think that would be a very important first step. Our hope is that even in such an interim step we could broaden the eligibility. Right now, that legislation would focus income eligibility at the SSI level rather than twice the poverty level.

But to respond most directly to your question, I think the first step would be to take the bill that is currently pending. It is a good bill as a step in the right direction, and I would urge that you enact H.R. 3933.

I would also say, Mr. Bliley, in response to your previous question to my neighbor from AARP, there was one major difference between the catastrophic health care legislation and the legislation that might flow from the Pepper Commission. Obviously, catastrophic did not deal with long-term care, but, beyond that, I think what you were hearing from were people who were concerned about a single generation tax for a single generation benefit. What the Pepper Commission has done that is different is, it has developed a multigeneration program that will be paid for by multigenerations. I think as a result of this kind of financing, the proposal is going to have greater receptivity.

Mr. BLILEY. The Commission cost estimates for that long-term recommendation, as you know, are $42.8 billion over 6 years. Is it possible to generate this much through a social insurance program and modest premiums for the beneficiaries?

Mr. POLLACK. As Chairman Rockefeller indicated, the average weekly cost for the long-term care benefit for those taxpayers who are not below the poverty line would be $4.50 a week. I believe, based on a wide variety of poll data that I have seen, that the American public would strongly support such a proposal. I think that as long as there is a clear linkage between the expenditure of those tax dollars to this kind of a benefit, families will overwhelmingly and resoundingly support paying for it.

Mr. BLILEY. You talked about applying $4.50 to workers. What about——

Mr. POLLACK. No, not per worker, per taxpayer.

Mr. BLILEY. Per taxpayer.

Mr. POLLACK. Correct.

Mr. BLILEY. Okay. So this would cover retired people as well as active people.

Mr. POLLACK. That is correct.

Mr. BLILEY. Okay. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Scheuer.

Mr. SCHEUER. Thank you, Mr. Chairman.

Mr. Chairman, I would like to ask the panel a single broad question.

When the Rockefeller commission, or the so-called Pepper Commission, reported to the American public and to the Congress recommending this form of a national health program as a cost of $65 to $70 billion, it was greeted with great cool, let us say, by both the public and the Congress because of the cost.

Now we have had hearings before the Congress describing the waste, and the duplication, and the overlapping, and the gap, and the interstices in our health system, the egregious lack of organization, the almost designed structured chaos in the system that is terribly wasteful. Karen Davis was one of our truly outstanding witnesses. We had witnesses like Hueve Reinhart of Princeton testifying that perhaps up to a quarter of all funds expended on health services were wasted; 25 percent of the $650 billion a year that we are spending now, he and Joe Califano, former Secretary of the Department of Health and Human Services, testified were essentially wasted for a wide variety of causes; I am sure you are familiar with most of them.

In your view, would it speed the way toward achieving national acceptance of a national health service program, including most or all of the goals that you are espousing, if we did have a concerted, well thought out effort to eliminate the duplication and overlapping and waste that are seemingly structured into the health care system that we have now? Or is that effort, almost by necessity, destined to be part of a national health care program as we move into it? How do we achieve these savings? Can we do it before we move into a national health care program, or is it going to be the result and one of the benefits of making the restructural rearrangements that will bring us to a national health care program? Any of you.

Ms. DAVIS. I think you are raising some very important points, and I think the Pepper Commission did have some very good recommendations on how we could improve efficiency and contain costs in the health care system generally and also in this area of long-term care.

It recommended expanding the jurisdiction of the Physician Payment Review Commission and the Prospective Payment Assessment Commission to not only look at Medicare's costs but to look at costs in the private sector. It emphasized the need for appropriateness guidelines so we could identify those health care services that are effective in improving health outcomes. It recommended reform of the private insurance industry to eliminate some of the abuses and duplication that are available there. It recommended expansion of health maintenance organization managed care op-

tions. It recommended a billion dollars to go into prevention and health promotion, to look at ways in which we could keep patients healthier.

In the long-term care area, I also think the Commission had some important cost containment provisions. It recommended case management so one would find the lowest cost, most effective way of taking care of a particular family. It targeted the benefits on those who are seriously in need. It set up a system for managing and delivering services, certifying providers, establishing a review and appeals process. It set standards for private policies for long-term care as well as those that would be available under this program.

So I think some of the recommendations would go a long way to achieving the kinds of objectives that you are setting forth so that those savings could, in part, be part of the financing for this plan.

But you said that this plan was dismissed because its costs were $65 billion, including coverage of the 37 million uninsured. I would reinforce Mr. Pollack's comment that, in fact, this is quite affordable, given the fact that we already spend $600 billion on the health care system and given that we are talking about over a trillion dollar Federal budget.

Estimates by the Joint Tax Committee, for example, indicate that simply lifting the cap on the payroll tax for both Social Security and Medicare disability insurance would generate over $18 billion worth of revenues in 1991. A modest increase in the payroll tax rate of 0.7 percent would raise $28 billion; eliminating the bubble in the income tax system would generate over $10 billion; and cigarette and alcohol taxes would provide $10 billion. I think there certainly are ways of affording this, particularly if we are talking about a phased in approach targeted on the most important needs first.

Mr. RENDISH. We think, too, Congressman, that there needs to be reform in regard to cost containment included in this comprehensive health care package.

We have a good situation right at home. We have two university hospitals 8 miles apart in two different States. One of the hospitals would like to purchase a CAT scan, and the other one also wants to purchase a CAT scan when one CAT scan machine could do for both hospitals.

Mr. SCHEUER. What was the outcome in that case?

Mr. RENDISH. The outcome is, both hospitals are going to purchase a CAT scan. This is unfortunate. We think there is a need for much improvement in delivery of health care services.

Mr. SCHEUER. Thank you.

Mr. WAXMAN. Thank you very much, Mr. Scheuer. I want to thank the members of this panel. You have been very helpful.

There may be some questions that members would want to ask you, and, if you would, we would like you to respond in writing for the record to those questions.

Thank you.

The purpose of our third panel of witnesses is to get the views of those involved with private long-term care insurance on the Pepper Commission plan.

Ms. Gail P. Schaeffer is second vice president of retail long-term care for the John Hancock Mutual Life Insurance Company. Ms. Schaeffer is appearing before the subcommittee today on behalf of the Health Insurance Association of America.

Representing the Blue Cross/Blue Shield Association is Ms. Mary Nell Lehnhard who is the organization's vice president of Government relations.

Finally, we will hear from Ms. Gail Shearer, manager of policy analysis for Consumers Union.

I want to welcome the three of you to our hearing today. Your prepared statements will be in the record in full. What we would like to ask of each of you is to limit your oral presentation to no more than 5 minutes.

Ms. Schaeffer, why don't we start with you.

STATEMENTS OF GAIL P. SCHAEFFER, CHAIRMAN, LONG-TERM CARE TASK FORCE, HEALTH INSURANCE ASSOCIATION OF AMERICA; MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS/BLUE SHIELD ASSOCIATION; AND GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION

Ms. SCHAEFFER. Thank you, Mr. Chairman.

At the outset, let me state emphatically that the Health Insurance Association of America applauds the efforts of the Pepper Commission to bring about consensus on the issue of long-term care. The HIAA agrees that the situation we have currently with regard to financing of long-term care is intolerable. We agree that we need to correct the problem of individuals impoverishing themselves from the high cost of long-term care. We feel that the problem can best be addressed by a specifically targeted Federal program combined with private long-term care insurance rather than by a broad public program.

The private long-term care insurance industry is a young industry but capable of enabling millions of Americans to provide for their own long-term care financing. Given scarce resources and competing national priorities for those resources, we believe that the Government should carefully target Federal funds to the neediest, with private insurance providing the solution for those who can afford and can access that insurance.

We know that problems exist with private insurance, and we feel these problems must be addressed. However, we feel that this can be done within the current system without establishing an entirely new system of regulation.

With regard to the specific proposals, the HIAA supports a number of recommendations in the Pepper Commission report. We support an expansion of the Government's role in ensuring the floor of financial protection in providing long-term care. We support the removal of long-term care from Medicaid and the establishment of a national program administered by States and localities. We support State responsibility for the control of costs, quality assurance, and consumer protection. We support clarifying the tax status of long-term care insurance to help reduce barriers to its development. We support the dissemination of nonbiased profession information on private long-term care insurance to educate con-

sumers about long-term care and options for financing it. And we support increased Government research in long-term care to find solutions which could ultimately reduce the need for and the costs of long-term care.

However, the Commission makes a number of recommendations which HIAA believe are problematic.

First, we do not support a social insurance program to cover unlimited home care and 3 months of nursing home care. The need for a Federal program must be weighed against both the inability of this country to pay for a social insurance benefit and the increasing number of people who will be protected in the future by private long-term care insurance. Given the growing number of people over the age of 65, the other extremely important national issues competing for scarce Federal dollars, and the emerging viable private market for long-term care insurance, we believe that any public expenditure must be carefully targeted to those most in need.

Second, HIAA does not support the Government providing the broad protection of assets as does the Pepper proposal. In our own research to solve the problem we, too, felt that increasing the level of protected assets in the case of a nursing home admission was important. However, we found that the increased tax funding required by the asset thresholds proposed by the Pepper Commission would primarily benefit the people who can afford private long-term care insurance. The existence of the private market frees our financially strapped Federal Government to limit asset protection to those who most need it.

The HIAA firmly believes that cooperative public/private financing and delivery arrangements should be promoted on an experimental basis. HIAA strongly supports the Robert Wood Johnson demonstration projects, one of which is in my own home State, Massachusetts, and we would urge passage of the Medicaid waiver legislation.

Third, HIAA does not believe that Federal regulation of private long-term care insurance is warranted. Although the effectiveness of State regulation of this product has been questioned in recent months, HIAA believes that the States can act responsibly and timely in regulating provisions in the sale of long-term care insurance. Thirty-seven States have adopted the NAIC model act since the beginning of 1987. We are working to assure that the rest will follow. The existing State structure for regulating long-term care insurance shows that States are much better equipped to attend to both the consumer needs and the oversight necessary to regulate long-term care insurance.

Mr. Chairman and members of the subcommittee, we believe that the current system for financing long-term care in this country is clearly unacceptable. However, by proposing a highly prescriptive national long-term care program, the Pepper Commission fails to build on the achievements already reached by the private sector. We believe the Government should target its limited resources to assist those who can least access and afford such protection. We look forward to working with you in this effort.

[Testimony resumes on p. 108.]

[The prepared statement of Ms. Schaeffer follows:]

STATEMENT

OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman and Members of the Subcommittee, I am Gail Schaeffer, Second Vice President, Retail Long Term Care, John Hancock Mutual Life Insurance Company. I am appearing today on behalf of the Health Insurance Association of America, in my capacity as Chairman of its Long-Term Care Task Force.

The Health Insurance Association of America represents 320 private health insurance companies which provide health insurance for 95 million Americans. We appreciate the opportunity to discuss the Pepper Commission recommendations with regard to long-term care as well as the private sector role in financing the nation's long-term care bill.

At the outset let me state emphatically that the HIAA applauds the efforts of the Pepper Commission to bring about consensus on the issue of long-term care. The report makes a number of recommendations which HIAA supports. However, the report also makes several recommendations which HIAA cannot support.

HIAA REACTION TO THE PEPPER COMMISSION'S RECOMMENDATIONS ON LONG-TERM CARE

Positive Elements

- HIAA supports an expansion of the government's role in ensuring a floor of financial protection in providing long-term care.
- HIAA supports the removal of long-term care from Medicaid and the establishment of a national program administered by states and localities.

- HIAA supports state responsibility for the control of costs, quality assurance and consumer protection.

- HIAA supports clarifying the tax status of long-term care insurance to help reduce barriers to its development, especially in the employer group market.

- HIAA supports the dissemination of nonbiased, professional information on private long-term care insurance to educate consumers about long-term care and options for financing it.

- HIAA supports increased government research in long-term care which would ultimately reduce the need and costs of long-term care.

Problematic Elements:

The Commission makes a number of recommendations which HIAA believes are problematic.

- HIAA believes that limited public tax dollars should be targeted to those most in need. Providing a social insurance program to cover unlimited home care and three months of nursing home care is prohibitively costly and it fails to account for the growing number of people who can be covered by private insurance. The need for a social insurance program must be weighed both against the increasing number of people who will be protected in the future by private long-term care insurance, especially employer-sponsored coverage, and against the ability of this country to prefund a social insurance benefit for a rapidly growing elderly population.

- HIAA believes that most persons should not rely on a public program if they can afford to purchase private insurance. Although HIAA agrees that eligibility for current public assistance under Medicaid is rather harsh, with most individuals having to spend down all their liquid assets, except for $2000 toward their care, the financial eligibility limits recommended by the Pepper Commission for the nursing home program are higher than they need to be to effectively target assistance to those most in need and thus are extremely costly to the taxpayers.

- HIAA believes that federal regulation of private long-term care insurance is not warranted. Although the effectiveness of state regulation against marketing abuses has been the focus of much debate in recent

months, HIAA believes that abuses are the exception, not the rule. We believe it is in the interest of both consumers and the health insurance industry to weed out any bad agents or practices that may exist but we believe it can best be done under the current regulatory system.

HIAA believes that the states have acted responsibly and timely in regulating the provisions and sale of long-term care insurance. 37 states have adopted the National Association of Insurance Commissioners (NAIC) Model Act since the beginning of 1987. The rest are expected to follow. The existing state structure for regulating long-term care shows that states are much better equipped to attend to both the consumer needs and the oversight necessary to regulate long-term care insurance. States have the ability to respond more quickly to both product and NAIC changes and federal standards for long-term care insurance, in any form, establish an unwarranted precedent that state regulation is not working.

The current system for financing long-term care is clearly unacceptable. Instead of pooling risks, it places each household on its own and Medicaid becomes the payor of last resort when household resources are depleted. This system, combining out-of-pocket outlays and welfare, features remediation and relief when prevention and planning would be preferable.

As indicated previously, the government should target its limited resources to assist those who can least access/afford such protection. Private insurance products are not designed for, nor do they lend themselves as, financing vehicles for people who are already quite old, disabled, or poor. Providing care for this population should be the objective of the public sector, and

reforms are needed to improve the government's ability to act as a responsible safety net for those who must rely on it.

By embarking on a highly prescriptive national long-term care program, the Pepper Commission fails to build on the achievements already reached by the private sector. But more disturbingly, the recommendations would create a new federal/state program at a stated cost of $42.8 billion per year when fully implemented. The size of the federal deficit and the national debt are staggering reminders that federal funds should be carefully targeted. The Pepper Commission's recommendations fail to meet this criteria.

HIAA POSITION ON LONG-TERM CARE

To summarize the HIAA position on long-term care the following points must be made:

- While the current "system" is flawed, the financing of long-term care is complicated and requires a thoughtful solution.
- Fiscal realities and other national priorities make it irresponsible to place the financing burden primarily on the nation's taxpayers via the federal government. All elements of society -- individuals, families, volunteer organizations, employers, and insurers must play a vital role.
- There is a growing and critical role for private insurance to provide a better means of financing long-term care for those who can afford to protect themselves.

- o There is a continued and indeed, greatly improved role, the government can play in financing long-term care for those without adequate resources to protect themselves.

- o There continues to be a critical government role, independent of financing care, in data collection and research to further our collective knowledge about who needs long-term care, what services should be provided, and what the total costs to society will be.

The HIAA firmly believes that cooperative public-private financing and delivery arrangements should be promoted on an experimental basis. A comprehensive national policy should be based on a full understanding of the alternatives and their cost-effectiveness.

Background

While there is increasing public awareness that long-term care is not a benefit of Medicare nor of Medicare supplemental insurance policies, the many facets of paying for prolonged health and custodial services in later years have yet to be solved for the majority of our citizens. The statistics speak loud and clear:

- o The lifetime risk of individuals over 65 entering a nursing home is at around 40 percent; it is almost 50% for women.

- o When an elderly person spends more than $2,000 per year out-of-pocket on health care, what has been described as "catastrophic" health care costs, 80 percent of that is likely to go to nursing home care.

- o New estimates peg the yearly cost of nursing home care at as high as $37,000.

- o About 9 million people will require long-term care by the turn of the century. Currently about 70 percent of

them receive care in their homes and communities from family members and friends. Another 30 percent need some type of paid assistance, and at one time or another 40 percent of all elderly will spend time in a nursing home.

- o Providing long-term care is more than a matter of financing it. Long-term care delivery systems are mostly uncoordinated and a mystery to most individuals needing to access them. In many cases where a nursing home placement is not desireable, it is often the only choice when other forms of long-term care assistance such as home health aides, adult day care, respite help simply do not exist.

New Developments in Long-Term Care Insurance

A national survey conducted last year by the University of Maryland's Center on Aging found surprising willingness by the public to purchase a long-term care plan if it met their long-term nursing home and home health care needs. Overall, over one-half of those surveyed indicated they would pay $100 a month for such a plan. At age 65 this $100 would buy five years worth of nursing home coverage at $36,000 a year or 10 years of at home care at around $18,000 a year. In addition, two-thirds of full-time workers said they would be more willing to purchase a policy if it were offered by their employer, even if the employee paid all or some of the premium.

The long-term care insurance market is developing rapidly, as evidenced by the number of companies developing products, the number of individuals covered and the variety of products being developed. There are now over 100 companies selling a long-term

care product and almost all of this growth is since 1985. Today, about 1.5 million persons have purchased a long-term care plan.

More importantly, the products themselves are changing. The earlier products tended to be more limited. For instance, they covered only stays in a nursing home and then only following a hospital stay. But virtually all the newer products offer coverage of nursing home and home health care, without institutional gatekeeping mechanisms like prior hospitalizations. Instead, benefits are often triggered based on the need for assistance in personal care functions such as bathing, walking, and dressing. In addition, they provide inflation protection against future long-term care costs. We will see a continued trend toward more comprehensive and liberal benefit provisions as the market place becomes more competitive.

The recent introduction of employer-sponsored plans is particularly promising. These employee pay-all plans offer the opportunity to reach a large number of people efficiently during their working years when premiums are more affordable. Coverage in the workplace offers the additional advantage of employers selecting the best plan at more affordable rates for their employees.

We believe that it is the employer market where significant growth will continue to occur. As of the beginning of 1990, only

nine insurers had sold coverage to employer-sponsored groups, and only 3% of all persons were covered under such arrangements. The number of employers offering this coverage however has grown exponentially from two employers in 1987, to five employers in 1988, to 47 in 1989 with another 64 expecting to enroll participants in 1990. Today, a total of 118 employers are offering long-term care insurance even without any tax clarifications.

In 1989, HIAA conducted a survey of the employer market and found that of the 57 plans with enrollment experience, a total of almost one half million employees have been offered a long-term care insurance plan. Most of the plans allowed employee's spouses, retirees and their spouses and the parents and parents-in-law of the employees to obtain coverage. The average age of active employees electing coverage is 43 years.

More than 10% of eligible persons were enrolled in employer-sponsored long-term care plans as of December 1989. About one half of the enrollees were active employees. The other half were retirees and their spouses and immediate relatives. This is an area where tax clarification and increased consumer education will lead to even further coverage.

Appropriate Public Financing Role

An estimated $56 billion was spent on all long-term care services in 1987. Over half, $30.6 billion, was paid by the public sector. Assuming no change in our current financing system, the Congressional Budget Office has estimated that this figure could increase between 50 and 200 percent by the year 2000.

Given today's fiscal realities and competing national priorities, we cannot expect the public sector to take on such an enormous and unwieldy financial responsibility. Instead, HIAA believes that public policy should be targeted toward finding ways to more effectively use the private resources already being spent for this care, thereby reducing future public long term care expenditures. Those who can afford to protect themselves should be encouraged to do so.

It is not the role of government to protect and preserve assets or income levels of individual citizens against the various contingencies of life. In general, it is the responsibility of individuals to plan for their own needs to the maximum extent possible. It is the role of government to provide sensitive and responsive support to those who face needs beyond their individual financial capacity to deal with them.

Educating the Public

The need for better consumer education is the responsibility of both the private and public sectors. It is virtually impossible to sell a product to someone who already believes they have it. However, this is where we find ourselves with long-term care insurance. Education should begin early, so that working age people can plan for their potential long-term care needs while they have the income to do so.

State Regulatory Environment

Long-term care insurance is a new product that continues to evolve. Insurers need a state regulatory environment which is sufficiently flexible to allow for the development of new and different products but is equally effective in protecting consumers. In December 1986, the National Association of Insurance Commissioners (NAIC) first adopted model legislation that successfully balances these two objectives. Since then, the model statute has been modified several times to better meet consumer need.

To date 37 states have passed the Model Act. Additionally nine states have some other form of long-term care regulation. In the remaining states the product is not unregulated, but falls under laws of general applicability. We are encouraged at the speed with which states have acted to govern this new product. As an industry, we must minimize the potential for consumer abuses if

we are to sustain a viable market. Therefore it is a top priority of HIAA to work actively in the remaining states for passage of the Act.

In addition to pursuing passage of the NAIC models, the HIAA Board of Directors has approved a consumer protection proposal developed by its members which includes recommendations in both the legislative and regulatory areas on such issues as marketing, education and product design. Effective regulation of long-term care insurance and meaningful consumer protection is in the interest of both consumers and the health insurance industry. Any bad agents or practices that may exist must be eradicated.

HIAA PROPOSAL FOR FINANCING LONG-TERM CARE

On May 6, 1990, the HIAA Board of Directors adopted a comprehensive proposal for financing long-term care which utilizes the inherent strengths of both the private and public sectors in a more efficient, focused and equitable manner than the essentially unstructured system in place today. HIAA has seen that given the knowledge and opportunity, the vast majority of Americans would prefer to make provision for their own long-term care needs through private savings mechanisms, especially those involving risk pooling. By thoughtful, competitive and broad-based expansion of such arrangements, the proportion of

long-term care financed by the private sector will gradually increase and will be distributed among individuals in a more rational fashion than it is today.

HIAA also believes that given competing national priorities, this nation cannot afford to pay for a broad long-term care program financed entirely out of taxpayer dollars. Besides reducing the federal deficit, a national public opinion poll conducted by the University of Maryland found that survey respondents believed strengthening the campaign against illegal drugs, improving public education and maintaining social security benefits were all more important problems than providing a federally subsidized system of long-term care for the elderly and disabled.

Secondly, as the current debate over the Social Security "surplus" highlights, HIAA does not believe it is politically feasible to adequately prefund a social insurance program required for long-term care. Even those organizations calling for social insurance advocate prefunding as essential; stating that the alternative places an ever-increasing tax burden on the next generation. Policy makers, however, have historically been unable or unwilling to prefund properly for future program benefits, relying instead on pay-as-you-go financing.

PRIVATE INSURANCE IS AFFORDABLE FOR A LARGE NUMBER OF AMERICANS

HIAA recognizes that it is people with adequate resources who will pay, either directly or indirectly, for their own care and the care of those who cannot afford to provide for themselves.

HIAA believes that, to the extent possible, persons of all ages should be encouraged to pay for their own care. Private insurance, through the lower average cost of risk sharing, gives more people the opportunity to use their own resources to do so. According to the estimates developed by LifePlans, Inc. and Boston University, about 40 percent of the current elderly could afford to purchase private long-term care insurance and affordability estimates are as high as 48 percent if only those aged 65 to 79 are considered.

These findings are supported in separate analysis conducted for AMEX Life Assurance Company using the Brookings/ICF long-term care financing model. This analysis found as many as two-thirds of the non-Medicaid eligible elderly aged 65-79 could afford their company's long-term care insurance policy if health expenses and long-term care premiums were less than 10 percent of available income. If more than 10 percent of personal resources were considered, estimates were even higher.

For the nonelderly, LifePlans estimates that between 50 and 70 percent of those in the workforce, as well as a high proportion

of nonworking spouses, represents the potential long-term care insurance market. Estimates were based on current pension and health insurance coverage. Clarification of long-term care insurance as health insurance in the federal tax code could push this figure toward the upper bound estimate. It is also important to note that affordability will become less of a problem at older ages as more persons purchase policies while they are working and are younger.

PUBLIC EXPENDITURES SHOULD BE TARGETED TO CRITICAL NEEDS

HIAA also recognizes that the private sector cannot realistically meet the entire need. There is a significant need for public sector involvement. This is true especially for the current generation of elders, who have not had the time, product availability or financial resources to provide effectively for themselves. HIAA believes that government should target its assistance to those who are in greatest need.

We believe this position is consistent with the views of the American public. In the same national poll cited above, 60 percent of respondents indicated that they would favor a government program that targeted its assistance for those in need rather than one providing coverage for everyone. For the 35 percent favoring a public program for all, willingness to pay estimated payroll taxes was highest among those over 65 and those with incomes below $20,000 and lowest among those under 49 and

those with incomes above $50,000. In other words, persons least likely to pay for the program's benefits were most in favor of its adoption.

Through targeted public assistance the government could minimize its spending and maximize coverage for those most in need. However, eligibility for current public assistance, i.e., Medicaid, is rather harsh -- most single persons are required to spend all their liquid assets, except for $2,000, toward their care, providing minimal resources to return to the community or to leave for their estate.

Analysis conducted by LifePlans indicates that allowing Medicaid eligibles to keep $8,000 in assets would increase current Medicaid spending 11.2 percent ($2 billion) while increasing the asset threshold to $12,000 would cost Medicaid an additional 18 percent or $3.2 billion in federal dollars. The cost of allowing persons to retain higher levels of assets and still qualify for Medicaid are marginal and the benefits accrue primarily to persons with incomes of $15,000 or less. As the asset threshold increases, the cost of the program would be greater and benefit higher income individuals. The increase in spending is minimized because these newly eligible persons would contribute more of their own resources toward the cost of their care than most of those who are currently eligible. Therefore, the public cost of providing care to this group is, on average, less.

HIAA also supports an increase in the nursing home personal needs allowance, which is currently $30 a month, although many states allow persons to retain $50 a month. We support the Pepper Commission recommendation which proposed that residents be allowed to keep $100 of their monthly income for their own use. LifePlans estimates that increasing the personal needs allowance to $100 a month (from a base of $50/month), would cost an additional $1.01 billion.

HIAA also advocates that Medicaid's institutional bias toward nursing home use be eliminated to encourage low and moderate income elderly to receive community-based long-term care services. Because Medicaid currently covers so little home care, most of these expenditures would be new. To be eligible for care, we propose using income eligibility criteria developed from the Medicaid long-term care waiver program to cover persons in the community with incomes up to 300 percent of the Supplemental Security Income limit (which varies for single and married persons). In addition, we propose that single persons be allowed to retain nonhousing assets valued up to $12,000 and that married couples be permitted to retain up to $24,000 in nonhousing assets.

Although cost estimates were not available, we recognize that this proposal is a relatively expensive one. However, we believe

that the benefits of home care are significant, that it is the responsibility of the public sector to target its assistance to those most in need, and that individuals should not be encouraged to use institutional care inappropriately. Furthermore, our approach to providing such coverage is more likely to be less costly than recommendations of the Pepper Commission which propose a broad $24 billion program to provide home care to severely disabled persons of all ages regardless of their ability to pay for their own care.

HIAA does, however, support the Pepper Commission recommendation that Medicaid form the basis for this new government program, but that this new program no longer be part of the Medicaid program. Such a reorganization would assist the states in administering the program, facilitate the development of uniform coverage criteria, remove long-term care from competing acute care coverage needs, and alter the current welfare perception of the program's long-term care benefits. Additional dollars necessary to fund the program should be contributed by the federal government.

A portion of this new program could be funded through estate recoveries of recipients after their death and the death of a surviving spouse. Although data are generally lacking, 1989 General Accounting Office (GAO) report estimated that as much as two-thirds of the amount spent for nursing home care for Medicaid

recipients who owned a home could be recovered from their estates or the estates of their spouses in the eight states studied. GAO recommended to the Congress that they consider making mandatory the establishment of state programs to recover the cost of Medicaid assistance provided to nursing home residents either from their estates or the estates of their surviving spouses.

Additional revenues could also be generated from strengthening the transfer of assets rules so that individuals could not give away property in order to qualify for Medicaid. Again, although data are generally lacking in this area, a 1989 study by the Office of the Inspector General of HHS found that people who were initially denied, but subsequently approved, for Medicaid nursing home coverage in Washington state possessed $27.5 million in assets at time of denial. At the time of Medicaid approval, it was determined that 70 percent of this money had been sheltered -- 59 percent was transferred to a spouse and 11 percent was transferred to adult children. Another 11 percent was considered exempt from Medicaid eligibility rules and only 8 percent was used to pay for long-term care. (The disposition of the remaining 11 percent was uncertain.)

GOVERNMENT ROLE IN EDUCATION IS ESSENTIAL

HIAA believes that the public will support neither private nor public sector efforts to address the long-term care financing problem unless they understand that it is, in fact, a problem.

Over the last several years, the insurance industry has made an extensive effort to inform the public about long-term care and its potential costs. Since 1987, when the HIAA long-term care consumer guide was first published, over one million copies have been distributed.

A primary conclusion of the LifePlans analysis is that the public's lack of knowledge about long-term care and the federal government's lack of a clearly articulated role in this area is inhibiting growth of the private market. To address this problem, HIAA believes that the federal government must take a stronger position in educating the public about limited government coverage for long-term care. The elderly need to understand the limitations of Medicare and Medicaid. Those under 65 need to understand how planning for potential long-term care expenses fits into their overall retirement needs.

In both cases, the goal of public and private sector education efforts is to allow consumers to make informed choices, which may or may not include the purchase of a long-term care insurance policy. If insurance is purchased, it is clearly in the industry's and consumer's best interest for individuals to clearly understand what they have bought.

The government could play several different roles in consumer education. One set of recommendations contained in the HIAA

February 1989 legislative policy framework paper includes the development of consumer guides on long-term care and long-term care insurance to be developed jointly by representatives from consumer, federal, state, provider, insurance and seniors' organizations; distributing these guides to all new Medicare beneficiaries, the Consumer Information Center and local referral agencies such as the Area Agencies on Aging; and conducting public radio and television announcements which inform the public about long-term care.

A more active government role is proposed by Senator Pryor in his recently introduced bill, "Health Insurance Counseling and Assistance Act of 1990" which would give states the ability to establish programs, using volunteers, to provide objective health insurance counseling to senior citizens. The bill would award block grants to states to establish and provide a program for delivering information, counseling and assistance to senior citizens concerning Medicare, Medicare supplement plans, long-term care insurance, Medicaid and other forms of health coverage. Funds would be made available for the training and continuing education of the counselors. In addition, a national resource center would be established to gather information pertaining to public and private health insurance counseling projects which would be disseminated to the states. HIAA has testified in support of the bill although we have raised specific questions

and issues regarding the program's implementation and structure.

Another approach for government education could be a nominal tax subsidy for the purchase of long-term care insurance. If targeted for the current elderly and phased out for purchases after a short period of time, it would benefit a group who did not have the opportunity to purchase such coverage when they were younger and the premiums were lower and as a result, now face the greatest affordability problems because of their age. This recommendation was first made in former Secretary's Bowen's 1986 report on catastrophic illness which called for a $100 credit toward the purchase of long-term care insurance. Although a nominal amount, the report concluded that the educational effects of such a credit far outweighed its monetary value by educating consumers about an important issue and as a result, would help to change attitudes as well. The LifePlans analysis indicates that a 10 percent premium subsidy, which on average approximates a $100 credit, would cost about $174 million. Although this analysis does not show a significant increase in the private market as a result of the subsidy, LifePlans' concludes that the model cannot capture the psychological and educational effects a government- sponsored premium subsidy might create. Therefore, the benefits of this approach in conjunction with a direct educational campaign should be considered.

SOCIAL INSURANCE IS COSTLY AND UNWARRANTED

As stated above, HIAA believes that social insurance proposals for long-term care are prohibitively costly and unwarranted given the potential of the private market. Moreover, the LifePlans analysis of social insurance proposals indicates that social programs are an ineffective use of public dollars. The marginal benefits from such programs most assist the elderly who need it least -- those with higher income and asset levels. They do very little to help the elderly with more modest resources, as compared to current public policy. This finding remains true regardless of whether the social insurance program pays for back-end catastrophic protection or only covers the first several months of care.

For example, a social insurance program which provides a lifetime home care benefit (with copayments and deductibles) and covers nursing home care after a 2-year deductible, is estimated to cost an additional $15.3 billion over current government spending. Over one-third of these expenditures would benefit those elderly with annual incomes of $30,000 or more. Another 40 percent would benefit those with incomes between $15,000 and $30,000. Less than 25 percent of the new benefits accrue to lower and moderate income elderly because this proposal mostly substitutes for current Medicaid coverage.

A social insurance program which provides total coverage for a lifetime home care benefit and covers the first year of nursing home care is estimated to cost an additional $19.7 billion over current government spending. About one-third of these expenditures would benefit those elderly with annual incomes of $30,000 or more. Another one-third would benefit those with incomes between $15,000 and $30,000. Like the approach modeled above, few benefits would accrue to lower and moderate income elderly because this proposal mostly substitutes for current Medicaid coverage. However, slightly more lower income elderly benefit from this approach over the one above because of the more comprehensive home care benefit.

PRIORITIES FOR ADDITIONAL PUBLIC SPENDING

Rather than spend tax dollars to provide long-term care to those who can afford to protect themselves, HIAA believes it is a higher priority to devote those public expenditures toward ensuring the delivery of quality long-term care services. Reimbursement policy under the targeted public program must be adequate to ensure quality care and deter cost-shifting to private paying patients. In addition, quality enforcement programs must be adequately funded and supported.

Government spending should also be targeted on research affecting long-term care use and costs, as recommended by the Pepper Commission, and support of demonstrations involving public-

private financing partnerships, such as those proposed by the eight states participating in the Robert Wood Johnson Foundation program. More resources are needed in basic and applied biomedical aging research to facilitate the management of chronic disease and disability. Treatments which ameliorate or control conditions such as Alzheimer's disease, incontinence, and osteoporosis will greatly enhance the quality of an older person's life and significantly reduce the need for costly long-term care services. The federal government must also continue its important function of organizing and collecting data through national surveys and share this information in a useful and timely manner. Financial support of such research and demonstration efforts are fairly minimal when compared to the tremendous benefits they will reap over the long-range.

SUMMARY OF HIAA POSITION:

As set forth in the analysis and discussion above, HIAA believes the role of the public sector in financing long-term care is:

- Clarifying the tax status of private long-term care insurance to help stimulate the development of the private market,
- Targeting its direct long-term care assistance to those who are in greatest financial need,
- Assisting the private sector in educating the public about long-term care through a variety of mechanisms,
- Ensuring the delivery of quality long-term care services, and

- Supporting research and demonstrations related to the need for long-term care services and public-private partnerships in paying for care.

SUMMARY AND CONCLUSION

The flexibility of private insurance offers families and the elderly the preferred approach to prefunding long-term care for many Americans. And, over time, we believe private insurance will give millions of people an opportunity to be financially independent throughout their retirement years.

HIAA believes it would be a mistake to minimize the role of private insurance in designing a comprehensive national policy for long-term care. Instead, the public and private sectors must combine their efforts and knowledge to create a solution that will benefit most Americans today and in the future. This investment will pay off many times over as you and I grow older and it will help us avoid placing an insupportable tax burden on our children.

Thank you for the opportunity to provide our comments and we look forward to working with you to provide further assistance in this area.

Mr. WAXMAN. Thank you very much, Ms. Schaeffer.
Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD

Ms. LEHNHARD. Mr. Chairman, Mr. Scheuer, I am Mary Nell Lehnhard with the Blue Cross and Blue Shield Association.

We support wholeheartedly the underlying concept of the Pepper Commission's recommendations—that is, to rely on a public/private partnership to address the long-term care needs of all Americans.

We are supportive of the Pepper Commission's proposal to encourage private long-term care insurance through clarification of the tax treatment of these products. Twenty-two Blue Cross and Blue Shield plans now offer long-term care insurance policies that are very comprehensive in nature. The Commission's recommendation would treat the premiums paid by employers and the benefits received by employees as health insurance for tax purposes. Qualified policies could also be sold as part of an employer's cafeteria plan.

We also support the Commission's recommendation for research targeted to prevent delay and deal with long-term care illnesses and disabilities.

While the Blue Cross and Blue Shield Association supports the overall goals of the Pepper Commission, we do have three concerns with their recommendations.

First, we believe the best mix of public/private sector involvement is to provide the private sector with the front-end role in financing long-term care. This role of ensuring the first dollars incurred, we believe, would maximize the strengths of the private sector while continuing the Federal Government's role as insurer of last resort. A back-end financing role for the private sector, as described in the Commission's proposal, makes less visible the need to purchase private insurance. We are concerned that individuals will have the misperception that they are fully insured for long-term care through a Government program when, in fact, they are not.

Our second concern relates to the Commission's approach of using Federal standards to regulate the long-term care market. We believe the State established standards based on the NAIC model are preferable. Among other things, the NAIC model act and regulations define a long-term care policy, establish certain disclosure and performance standards for insurers, prohibit post-claims underwriting, and establish minimum standards for certain benefits, including home health services and inflation protection.

The NAIC has acted quickly, we believe, to protect consumers in this developing market without stifling growth or innovation. The Blue Cross and Blue Shield Association and its member plans have worked with the NAIC, we believe, to develop appropriate consumer protections. However, if the Congress concludes that establishment of a Federal voluntary certification program for long-term care insurance is necessary to encourage the States, we would support such action, provided that the Federal program incorporates the standards approved by the NAIC.

Our third concern is that in today's fiscal environment, major new programs need to be matched with revenues needed to sustain those programs. Given the financial constraints facing the Government, the comprehensive coverage suggested by the Pepper Commission will be very difficult to achieve. We believe that a realistic step for the Federal Government at this point is to use any additional funds to help finance comprehensive and high quality long-term care coverage for those who can't participate in the private market—that is, the low income, the already disabled, and the very old.

We also have some recommendations beyond those made by the Commission.

First, we recommend that insurers be allowed to establish long-term care insurance reserves on a tax-favored basis 1 year after the insurance has been in force. Under current law, long-term care policies, because they are treated as noncancellable accident and health insurance, can start building their reserves only after 2 years. Allowing buildup under 1-year requirements would, we believe, help insurers keep the cost of the coverage as low as possible.

Second, we strongly support a Government role in clarifying for individuals the nature, extent, and risks of potential long-term care expenses—that is, an educational role for the Federal Government. We believe that many older people continue to be under the impression that Medicare provides for long-term care insurance. This perception is slowly changing, but it is clearly a major obstacle to being able to sell private coverage.

I appreciate this opportunity to testify and would be glad to answer any questions.

[Testimony resumes on p. 124.]

[The prepared statement of Ms. Lehnhard follows:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, and Members of the Subcommittee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 74 Blue Cross and Blue Shield Plans nationwide.

We commend the work done by the Pepper Commission and appreciate the opportunity to comment on the commission's proposal for providing long term care services.

My testimony will focus on three areas:

- The current and future role of private long term care insurance;
- Our comments on the Pepper Commission's proposal on long term care and the role the proposal gives to private insurance; and
- Our recommendations for a public-private partnership in long term care.

The Blue Cross and Blue Shield Association recognizes that there is a very serious need for long term care coverage. We believe that a public-private partnership is needed to address this problem.

Most seniors continue to face extreme financial hardship if they need long term care in nursing homes or in their own homes. Private insurance, despite significant growth in the last few years, currently reaches only a small portion of the population at risk, and Medicaid, the major public program for financing long term care services, requires individuals to become impoverished before becoming eligible.

We believe the private long term care market will grow and that there are ways the federal government can encourage the development of this market. However, we recognize that the private sector cannot address the needs of all segments of the population. Persons already 80 years old and over, people currently suffering from chronic illness, and low-income individuals generally will not be able to purchase private insurance coverage. As a result, we believe there are critical roles for both the federal and state governments and the private sector to address the long term care needs of Americans.

DEVELOPMENT OF PRIVATE LONG TERM CARE INSURANCE MARKET

The long term care market has come a long way in a very short time. In 1986, there were only 130,000 long term care insurance policies sold compared with the more than 1.5 million policies sold by the end of 1989.

Over the past few years, many Blue Cross and Blue Shield Plans have developed products. Twenty-two of our Member Plans are

currently marketing these policies compared to only four years ago. Several more are expected to enter the market in the near future.

Long term care products have changed significantly over this period. Most of the industry's earliest policies were quite restrictive. These policies typically offered nursing home coverage only and required prior hospitalization before individuals could receive benefits. Other types of care, such as home care or custodial care, were seldom offered.

In contrast, recently developed long term care insurance policies tend to offer benefits that meet a variety of needs. In addition to care provided in all levels of nursing homes, Blue Cross and Blue Shield long term care products may cover a wide variety of home and community-based health services, including home health visits, adult day care, homemaker services, medical transportation and respite care. Few policies have prior hospitalization requirements and those that do generally offer this as an optional benefit.

Many policies also provide the services of a case manager to work with the client, family and physician to develop a plan of care and help monitor treatment. Other features in some of our policies include the following benefits:

o Return of premium. If a subscriber dies before using the benefit, a portion of a subscriber's premiums are returned to a beneficiary;

- Non-forfeiture of benefits. If a subscriber discontinues payment of premiums after a minimum number of years, the subscriber does not forfeit all benefits but is entitled to reduced benefits; and
- Paid-up options. An individual can pay higher premiums for a fixed number of years after which the policy is paid in full and the subscriber is entitled to the full level of benefits.

Although long term care benefits may be needed by persons of any age, policies have focused on services needed by older populations. Policies generally are available to persons between the ages of 40 and 79. Premiums vary with age at initial purchase and with the benefit options selected and remain the same over the life of the policy. All of our products are guaranteed renewable.

Some Blue Cross and Blue Shield Plans offer benefits in their long term care products which base payment on a percentage of the cost of services received rather than a fixed daily "indemnity" benefit. This type of payment structure helps keep pace with health care cost inflation. Other policies are designed to protect against inflation by incorporating features such as annual benefit increases (i.e., annual percentage increases in fixed payment amounts for covered services), or periodic opportunities to increase benefit levels.

In recent years, employers have shown a growing interest in offering long term care policies to their employees. In 1987 only two employers nationwide offered coverage to their employees. This number is expected to increase to 118 employers in 1990. While most of these are large groups, mid-size employers are beginning to offer coverage as well.

There are many advantages to long term care policies sponsored through employer groups. Policyholders are usually younger (average age is 43 years) than those enrolled in individual policies (average age is 72 years) and, as a result, premiums are lower. For example, for the same policy, the annual premium for a 50 year old is $236 while the premium for a 70 year old is $1,468. Also, due to lower administrative and marketing costs, the premiums for group-sponsored products are generally lower than those of individual policies. Employer group plans also reach a broader range of people. Coverage is usually offered to active employees, spouses, and/or retirees. In some cases, parents and in-laws are offered the opportunity to purchase through the group. The employer sponsorship also lends credibility to the product through the scrutiny of experienced and knowledgeable benefits managers who select and examine the product for quality and value on the employees' behalf.

As the long term care insurance market has grown, the NAIC has aggressively moved to develop standards to protect consumers.

The Model Act was adopted by the NAIC in 1986 followed by a comprehensive set of Model Regulations in 1987. Further changes have been made each year including:

- A prohibition on prior hospitalization requirements
- A requirement that questions about an applicants health be clear and unambiguous
- A prohibition of certain restrictions on access to home health care benefits
- A requirement that insurers offer an inflation protection for benefits

Just last week the NAIC approved a requirement that a shopper's guide to long term care insurance be provided prior to presentation of an application or enrollment form.

The Model Act and Regulations or some more stringent variation have been adopted by 40 states. NAIC president Earl Pomeroy has requested a committee to prepare a draft of additional consumer protection amendments. The NAIC is acting to protect consumers in this developing market without stifling growth or innovation. The Blue Cross and Blue Shield Association has been working with the NAIC to develop appropriate consumer protections.

THE PEPPER COMMISSION PROPOSAL

In March, the Pepper Commission released a summary of its proposal to provide long term health care benefits. The three-part recommendation would: 1) provides home and community-based care to all individuals, regardless of their income levels, who need assistance with three or more activities of daily living (ADLs) or who have a severe cognitive impairment; 2) provides for the first three months of care for anyone receiving nursing home benefits, again without regard to income levels; and 3) provides nursing home benefit for individuals who have nursing home stays beyond three months in duration with protection of non-housing assets up to $30,000 per year.

Under this proposal, individuals would be responsible for a 20 percent copayment for home and community-based care, and for the first three months of a nursing home stay. Federal subsidies would be available to cover the copayment for individuals with incomes below 200 percent of the federal poverty level. The federal government would contract with states to administer all three components of the plan.

Further, the federal government would establish minimum standards for private long term care policies that would fill gaps in coverage. States would be responsible for regulating private long term care insurance, using standards at least as

strict as guidelines developed by the federal government. Private policies meeting these standards would qualify for preferential tax treatment.

The net cost of the Pepper Commission's long term care recommendations upon full implementation would be $42.8 billion annually.

The Blue Cross and Blue Shield Association supports the underlying concept of the Pepper Commission recommendations that a public-private partnership is needed to address the long term care needs of all Americans. We are supportive of the Pepper Commission's proposal to encourage development of private long term care insurance through clarification of the tax code. The commission's recommendation would treat the premiums paid and the benefits received as health insurance for tax purposes and would enable qualified long term care policies to be sold as part of employers' cafeteria plans.

While the Association supports the goals of the Pepper Commission, we have three concerns with their recommended approach:

1. We believe that the Pepper Commission does not provide a truly significant role for private long term care insurance.

We believe that the growth in the market to date clearly shows that many people <u>are</u> willing and able to insure themselves

against the cost of long term care expenses. By encouraging people to focus on their long term care needs at earlier ages, even more individuals could afford protection against the costs of long term care. Studies undertaken by Brookings estimate that up to 43 percent of the population could afford private policies if people began purchasing such policies during their working years.

The approach taken by the commission severely limits private sector involvement to gap filling coverage for catastrophic (i.e., "back-end") care. We believe the best mix of public-private sector involvement is to provide the private sector with a "front-end" role in financing long term care. This "front-end" role would maximize the strengths of the private sector while continuing the federal government's role as insurer of last resort.

We believe this approach encourages individuals to plan ahead and purchase private sector long term care products at younger ages when rates are more affordable. Such an approach also would build on the private sector's strengths in containing cost and designing benefit packages that best meet the needs of consumers.

A back-end long term care financing role for the private sector program, as described in the Pepper proposal, makes less visible the need to purchase private coverage by giving

individuals the misperception that they are fully insured for long term care expenses through a government program.

2. We believe that state-established long term care insurance standards based upon the NAIC model is preferable to the federal long term care standards proposed in the commission's recommendations. We urge the federal government to recognize the flexibility needed when considering the establishment of federal long term care standards such as those proposed by the Pepper Commission.

The Blue Cross and Blue Shield Association and Member Plans support the leadership role taken by the National Association of Insurance Commissioners (NAIC) in establishing flexible standards that assure consumer protection and choice.

Among other things, the NAIC model act and regulation defines a long term care policy, establishes certain disclosure and performance standards for insurers, prohibits post claim underwriting, and establishes minimum standards for certain benefits including home health and inflation protection.

We support the development and adoption of NAIC model standards for state regulation of long term care insurance policies. If, however, the Congress concludes that the establishment of a federal voluntary certification program for long term care insurance policies is necessary to encourage state efforts in this area, we would support such action, provided that the

voluntary federal certification program incorporates the standards developed by the NAIC, not Congressionally-developed revisions or new Congressional standards.

We also would recommend that if the Congress enacts a certification program based on the NAIC model standards that it monitor changes in these standards and promptly revise the federal legislation as necessary.

3. In today's fiscal environment, major new programs need to be matched with the revenues to sustain such commitments. Given the financial constraints facing the government, the comprehensive coverage suggested by the Pepper Commission will be very difficult to achieve.

BCBSA RECOMMENDATIONS

Recognizing the budgetary problems Congress is facing as well as the impact of the Medicare Catastrophic Act, the Blue Cross and Blue Shield Association recommends that the federal government use its limited federal funds to do the following:

1. Establish tax incentives. Tax incentives would encourage the development and sale of private long term care policies to those who could afford coverage. Specifically, we suggest:

o Individual Deductions We suggest that individuals be permitted to deduct qualified long term care expenses and

premiums using the limited medical expense deduction allowed under Section 213 of the Internal Revenue Code. This section allows individuals to deduct medical expenses in excess of 7.5 percent of their adjusted gross income.

- Tax Exclusion for Employer-Provided Long Term Care Benefits We also recommend that long term care insurance be given the same tax-favored status granted to group health benefits. Specifically, benefits paid out and employer contributions for long term care insurance would be excluded from an employee's income. Also, we believe that employers should be allowed to deduct contributions to a long term care plan as a current expense and to offer long term care coverage as part of a cafeteria plan.

- Calculation of Long Term Care Insurance Reserves Finally, we recommend that insurers be allowed to establish long term care reserves on a tax-favored basis after the insurance has been in force for one year. Allowing reserve build-up under the one year method would help insurers keep premiums as low as possible.

2. Improve public program for those not reached by private insurance. We believe that a realistic step for the federal government at this point would be to use any additional -- albeit limited -- funds to help finance comprehensive and high

quality long term care coverage for those who cannot participate in private programs -- that is, the low-income, the disabled and the very old. This objective might be met by modifications to the Medicaid program -- such as providing home and community-based benefits for individuals up to the poverty level.

3. Expand public long term care education activities. We strongly support a government role in clarifying for individuals the nature, extent and risks of potential long term care expenses. Many older people continue to be under the impression that Medicare provides coverage for long term care. While this perception is slowly changing, public misunderstanding on this issue is clearly a major obstacle to the expansion of needed long term care coverage.

We would also support government efforts to educate the public regarding eligibility criteria and benefits covered under the Medicaid program. This would give those individuals not eligible for government long term care benefits or who do not wish to spenddown to Medicaid the opportunity to plan, if possible, for their long term care needs in advance -- before private coverage is unattainable.

Conclusion

The Blue Cross and Blue Shield Association endorses the basic concept of a public-private partnership as the most promising

approach to assuring the availability of long term care services. We believe that, at this time, the best mix of public-private involvement would be for the federal government to support the development of the private sector long term care market for those who have access to such coverage and use its limited federal dollars to provide or improve long term care coverage for others for whom private insurance is not a viable option. If after several years, this approach proves inadequate and a feasible financing approach can be devised, the Congress may find it appropriate to consider an expanded role.

We would urge the Congress to clarify, as soon as possible, the tax status of long term care products and to educate the public as to what benefits are and are not covered under public programs and that consumer protection standards be flexible enough to allow for innovative growth.

We want to thank you for this opportunity to testify before the committee and we would be pleased to work with you as you continue to search for ways to finance long term care services.

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Mr. WAXMAN. Thank you very much.
Ms. Shearer.

STATEMENT OF GAIL SHEARER

Ms. SHEARER. Mr. Chairman and Mr. Scheuer, Consumers Union appreciates the opportunity to present our views on the Pepper Commission recommendations regarding long-term care.

We believe that the Pepper Commission's long-term care recommendations call for an appropriate mix of public and private roles in solving the long-term care problem. We have found that private long-term care insurance is not presently serving consumers well. Some of the problems are fixable. State insurance regulators can and, hopefully, will develop regulations to ensure that purchasers are protected against erosion of benefits by inflation, unscrupulous marketing and claims handling practices, unfair pricing practices, possible insurer insolvency, and other risks of the market.

But the private long-term care insurance market alone cannot solve the Nation's long-term care problem. The private insurance market cannot help people who need long-term care because of a birth defect or tragic accident early in life. It cannot help people whose health conditions place them at high risk of needing long-term care and, therefore, cannot qualify for a policy. And it cannot help people who simply cannot afford the high cost of a policy year after year.

In my testimony, I will outline the principles we believe should guide the development of a public long-term care program and comment on some of the Pepper Commission's recommendations.

Consumers Union believes that the Government needs to take an active role in solving the long-term care problem. The principles that should guide development of a public program are as follows. It should protect people of all ages. It should be financed progressively. It should be comprehensive and universal. It should be self-funded. Administrative costs should be minimized. Cost sharing should be an integral part of the program, but should not impose undue hardship. Cost control and quality control should be built into the program. Costs should be shared equitably between generations. Regulation of the private market should be effective and strictly enforced. And, finally, public costs should be minimized while meeting consumers' needs.

I would like to briefly expand on the most important principle, that the program should be comprehensive and universal. The program should cover both home health care costs and nursing home costs, and it should protect all Americans at risk of needing long-term care on a mandatory basis.

In the long run, we believe the country should move away from a welfare approach to funding long-term care. The welfare approach is extremely inequitable. Since taxpayers already pay a large share of long-term care costs, public policy makers should understand why so many seek legal help to exploit loopholes to allow them or their parents to qualify for Medicaid.

It does not seem fair to reward relatively sophisticated families with qualification for long-term care coverage and leave others, who comply with the spirit of the program, without any protection.

We believe that a public program that protects all Americans against the devastating costs of long-term care is the best way to correct these inequities. Benefits should be available based on need, and revenues should be collected based on ability to pay. Resistance to higher taxes should be softened, because all Americans would benefit from the program, whether rich or poor.

While the Pepper Commission has not yet elaborated on proposals for how to finance its long-term care program, the components of its long-term care program are consistent with the parameters that we have outlined, and its proposed financing criteria are sound. Some of its most significant features follow.

The recommendations reflect the fact that the long-term care problem is not affecting the elderly alone. They encourage home- and community-based care; provide front-end, first 3 month nursing home coverage; and impose a reasonable cost sharing charge for people over 200 percent of the poverty level. They increase the level of assets protected before an individual becomes eligible for Medicaid benefits for long-term, lengthy nursing home stays. And they recognize the Federal Government's responsibility to establish minimum Federal standards for private long-term care insurance which would wrap around a Federal program.

We commend the subcommittee for holding today's hearing. The long-term care problem is one that will only grow larger with time. Congress has an opportunity now to alleviate an enormous amount of human suffering by establishing a compassionate program to protect all citizens of our country against costs that can wipe out a family's savings very quickly.

We urge you to carefully review the Pepper Commission's long-term care recommendations, and we are eager to help you as you continue on this important issue.

[Testimony resumes on p. 140.]

[The prepared statement of Ms. Shearer follows:]

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Testimony of

GAIL SHEARER

MANAGER, POLICY ANALYSIS

CONSUMERS UNION

Mr. Chairman and members of the Subcommittee, Consumers Union[1] appreciates the opportunity to present our views on the Pepper Commission recommendations regarding long-term care. The issue of long-term care has been a high priority for Consumers Union during the past two years both in terms of the product ratings in **Consumer Reports** and our advocacy efforts. In May 1988, **Consumer Reports** rated 53 private long-term care insurance policies. In October 1989, we published an update of the earlier article. In January 1989, our Washington Office issued the report: Long-Term Care: Analysis of Public Policy Options. In addition, we have been actively involved in both reviewing and developing proposals before the Congress and state regulators to improve the functioning of the private long-term care insurance market.

We have found that the private long-term care insurance is not presently serving consumers very well. Some of the problems are fixable: state insurance regulators can (and hopefully will) develop regulations to insure that purchasers are protected against erosion of benefits by inflation, unscrupulous marketing and claims handling practices, unfair pricing practices, possible insurer

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[1]Consumers Union is a nonprofit membership organization, chartered in 1936 under the laws of the State of New York to provide information, education, and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 4.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

insolvency, and other risks of this market. Perhaps they will even take steps to simplify the market and make it possible to compare premiums for identical policies, to help prevent the abuses that occur because consumers can not possibly understand the restrictions contained in the fine print. But we have also concluded that the private long-term care insurance market alone can not solve the nation's long-term care problem. The private insurance market can not help people who need long-term care because of a birth defect or tragic accident early in life. It can not help people whose health conditions place them at high risk of needing long-term care and therefore can not qualify for a policy. And it can not help people who simply can not afford the high cost of a policy, year after year.

We believe that the Pepper Commission's long-term care recommendations call for an appropriate mix of public and private roles in solving the long-term care problem. In my testimony, I will elaborate on some of the concerns we have about the private long-term care insurance market, outline the parameters we believe should guide the development of a public long-term care program, and comment on some of the Pepper Commission recommendations.

ROLE OF THE PRIVATE LONG-TERM CARE INSURANCE MARKET

Consumers Union believes that the private market can not be expected to solve the nation's long-term care problem for a number of reasons. Companies reject as many as 30 percent of applicants, those with higher than average health risks. Policies are expensive, costing up to $100 per month for a 65-year-old, and much

more for older applicants. Policies often restrict benefits for certain types of care (e.g., custodial), and consumers seldom fully understand the implications of the fine print in the contracts. "Gate-keeping" techniques (which screen worthy beneficiaries from those who do not qualify for benefits) are imperfect; while many companies are turning away from "prior hospitalization" requirements (which had the effect of denying protection to roughly 60 percent of nursing home entrants), 28 states still allow companies to require prior hospitalization before paying claims. Many companies are using "activity of daily living" (ADL) screens, which look at a patient's ability to perform routine daily activities such as eating and bathing. Even ADLs are far from perfect. One problem with ADLs is that many people with Alzheimer's Disease do not have serious ADL limitations. Another problem is that definition and measurement of ADLs can vary, resulting in a large variation (45 percent) in how many people in a community with serious ADL limitations actually qualify for a policy.[2]

Failure to adequately protect against inflation is another flaw of many policies. While more companies offer an inflation rider now than in 1988, many of the riders are limited. We do not believe that policies with modest (but limited) benefit increases protect adequately against inflation. For example, a policy with

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[2]Joshua M. Wiener, Ph.D., "Standards for Private Long-Term Cared Insurance; How Tough and Whose Job?," Testimony before the Subcommittee on Health, Ways and Means Committee, U.S. House of Representatives, May 17, 1989.

a 5 percent per year increase for 10 years (less if the policyholder reaches a certain age) leaves a 20-year policyholder with inadequate protection against high inflation levels. A 7 percent per year inflation rate in policy years 10 through 20 would cut the policy benefits in "real" terms in half.

Another problem is the typical company policy of not providing a refund in the event the policyholder discontinues the policy.[3] Policyholders who drop their policy, perhaps to buy a better policy, are typically out of luck. We believe that policyholders who drop their policy after a certain amount of years of paying premiums should be eligible for some sort of compensation (e.g., a reduced paid up benefit), since early year premiums are used to subsidize later year risks. Health actuary Gordon Trapnell recently told the Oversight and Investigations Subcommittee that:

> The dirty little secret of the long term care insurance business is that most of the companies issuing policies do not expect them to remain in force long enough to benefit the purchasers. The insurers assume that most will eventually fail to pay the premiums, and let their policies "lapse." And no mater how much has been paid before they lapse, the policyholder will receive nothing.[4]

According to Trapnell, companies assume that 5 to 30 percent of their policyholders will fail to renew their policy each year, to the benefit of the company.

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[3]In insurance parlance, this issue is referred to as "nonforfeiture values."

[4]Testimony of Gordon R. Trapnell before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives, Hearings on Regulation and Sale of Long Term Care Insurance, May 2, 1990, p. 4.

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The private market is not well suited to insuring the long-term care needs of people under age 65. At a hearing held by the Pepper Commission, it heard the compelling stories of a family who struggles to meet the daily needs of a husband crippled by multiple sclerosis and of a family whose child requires round-the-clock access to medical care because of a birth defect. Private long-term care insurance is unable to help families like these who are in need today, or other young families who are at risk of having long-term care needs before the age of 65.

Furthermore, the private market is expected to divert 40 to 50 percent (or more) of premiums collected to cover administrative and marketing costs, and profits. In contrast, the Medicare system spends 97 percent of revenues on benefits.

Another deficiency of the private market is unfair pricing practices. Most long-term care policies are "level-premium" policies. This does not mean that premiums will remain level. It means that premiums will not automatically increase each year as the policyholder ages. Companies with "guaranteed renewable" policies are free to increase the so-called level premium if they increase it for everyone else in the state with the policy. This amounts to "bait, lock-in and switch" for consumers, who are forced to make a purchase decision without knowing the cost in future years. This leads to strange incentives for insurance companies. Companies have a strong incentive to underprice the policy initially in order to attract customers, and then raise premiums

in later years, after consumers are locked in.[5]

Unscrupulous insurance company and agent practices have also created major problems for consumers. The October 1989 issue of **Consumer Reports** tells the story of three victims of the troubling practice of "post-claims underwriting" -- the practice of checking a policyholder's medical history only after a claim is filed, instead of when an application is taken. It is very difficult for a consumer to predict at the time of purchase whether the company is likely to honor a legitimate claim made in the future.

All of these considerations affect the appropriateness of private long-term care insurance for individual consumers. From a public policy perspective, however, there is one overriding consideration that affects whether the private market can solve the problem -- affordability. Even under optimistic assumptions about people's willingness to buy policies, the Brookings Institution estimates that a fairly limited private insurance policy could be purchased by only 25 percent of the elderly by the year 2018. Such coverage could make an insignificant reduction in Medicaid long-term care expenditures, reducing the number of nursing home patients whose expenses are covered by Medicaid by only 2.3 percent

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[5]Companies that deliberately underprice their premiums (to undercut the competition) and then raise them in later years create one type of consumer victim. Companies that continue to underprice their product risk insolvency, creating another type of consumer victim, whose long-term care claims can not be honored.

in 2018.[6]

Therefore, we recommend that the Congress reject options that would promote private long-term care insurance by preferred tax treatment for individuals or by tax preferences. This type of approach would inevitably collect tax revenues from a broad range of income groups, and provide additional private long-term care insurance (with the limitations noted above) to relatively high income people. We note, though, that some tax changes would be acceptable if they were part of a broad package that included adoption of the Pepper Commission recommendations for a public long-term care program. If this were the case, tax changes would provide a vehicle for relatively well-off individuals to purchase private long-term care insurance against long nursing home stays. The public program would provide long-term protection for people of modest income and assets.

Several states are planning demonstration projects that will liberalize the Medicaid spend-down requirement for people who purchase state-sanctioned long-term care insurance. These projects face (at least) two major challenges: improving the performance of the private market so that the state is not in the position of encouraging the purchase of a flawed product, and assuring equitable treatment across income groups.

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[6]Alice M. Rivlin and Joshua M. Wiener, Caring for the Disabled Elderly -- Who Will Pay,? The Brookings Institution, 1988, p. 77 and p. 80.

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CONSUMERS UNION SUPPORTS

PUBLIC LONG-TERM CARE PROGRAM

Consumers Union believes that the government needs to take an active role in solving the long-term care problem. The parameters that should guide development of a public program are:

1. The program should protect people of all ages;
2. The program should be financed progressively;
3. The program should be comprehensive and universal;
4. The program should be self-funded;
5. Administrative costs should be minimized;
6. Cost-sharing should be an integral part of the program, but should not impose undue hardship;
7. Cost control and quality control should be built-in to the program;
8. Costs should be shared equitably between generations;
9. Regulation of the private market should be effective and strictly enforced; and
10. Public costs should be minimized while meeting consumers' needs.

Each of these parameters is explained in detail in Consumers Union's January 1989 report, Long-Term Care: Analysis of Public Policy Options. I would like to briefly expand on three of them.

The program should protect people of all ages.

A long-term care program should cover people of all ages, not just people over 65 years old. Many younger people are disabled or chronically ill. Approximately 40 percent of people who need personal assistance because of inability to perform one or more

"activities of daily living" are under age 65.[7] Children and young adults are the people least likely to purchase private long-term care insurance, and are least likely to be able to plan ahead for future long-term care costs. The large costs involved make it necessary to turn to people under age 65 for at least some of the funding of a long-term care program; covering their long-term care risks will make the long-term care program more appealing as well as fairer to them.

The program should be comprehensive and universal.

The program should be comprehensive, covering both home health care costs and nursing home costs. It should be universal -- protecting all Americans at risk of needing long-term care on a mandatory basis.

One public policy option is expanding Medicaid coverage of long-term care. This could be done, for example, by increasing the assets and/or income level that could be retained when qualifying for Medicaid. We certainly support the increased protection against spousal impoverishment that were included in the 1988 Medicare Catastrophic Coverage Act and preserved when the Act was repealed.

In the long-run, however, we believe the country should move

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[7]Linda H. Aiken, "The Aging of America: Implications for State Policy," Building Affordable Long-Term Care Alternatives: Integrating State Policy, National Governors' Association, Center for Policy Research and Analysis, Washington D.C., April 1987, p. 11, quoted in "Long Term Health Policies," Report to Congress and the Secretary by the Task Force on Long-Term Health Care Policies, September 21, 1987, p. 18.

away from a welfare approach to funding long-term care. The Medicaid share of nursing home costs is already high, 43 percent.[8] Even without a change in public policy, the increasing number of elderly would increase the Medicaid long-term care expenditures in the coming decades. The welfare approach is extremely inequitable. Since taxpayers already pay a large share of long-term care costs, public policy makers should understand why so many seek legal help to exploit loopholes to allow them (or their parents) to qualify for Medicaid. The Office of Inspector General of the Department of Health and Human Services describes some typical comments from state staff involved in transfer of assets that are related to Medicaid qualification:

-- "People are starting to use a lot of fancy footwork to avoid losing the 'family fortune.'"

-- "If an applicant or recipient is over assets, they can reduce their assets by buying any exempt or excluded asset and requalify for assistance . . . Families buy vehicles and even diamond pendants to qualify [exclude] the assets. Personal property is excluded so it can be given away at any time."

-- "Many, many, many attorneys call on a daily basis looking for 'loopholes.' There are lots of welfare specialists who help people avoid welfare resource limits."[9]

It does not seem fair to reward relatively sophisticated families with qualification for long-term care coverage, and leave

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[8]Alice M. Rivlin and Joshua M. Wiener with Raymond J. Hanley and Denise A. Spence, Caring for the Disabled Elderly: Who Will Pay?, The Brookings Institution, Washington, D.C. 1988, p. 42.

[9]Richard P. Kusserow, Inspector General, Department of Health and Human Services, **Medicaid Estate Recoveries**, June 1988, p. 12.

others who comply with the spirit of the program without any protection. We believe that a public program that protects all Americans against the devastating costs of long-term care is the best way to correct these inequities. Benefits would be available based on need; revenues would be collected based on ability to pay. Resistance to higher taxes would be softened because **all** Americans would benefit from the program, whether rich or poor.

Costs should be shared equitably between generations.

The recent controversy over the catastrophic bill highlights the challenge Congress faces when trying to achieve an equitable sharing of costs between generations. The costs of long-term care (averaging $1300 per person over age 65)[10] are too high to be borne by the elderly alone. Since we believe that coverage of people of all ages is a necessary component of a long-term care program, it follows that people under age 65 should share in the bill. The least painful way for an individual to pay his or her own long-term care risk is in small payments spread throughout his or her entire working life. It is too late for people who are over 65 to do this. People over 65 should share the cost of a long-term care program through premiums, increased estate taxes, and cost-sharing.

It would be relatively easy to develop a long-term care program if unlimited money were available. The challenge facing the Congress will be to shape a long-term care policy in the

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[10]Alice M. Rivlin, Joshua M. Wiener, et. al., "Who Should Pay for Long-Term Care for the Elderly?," The Brookings Review, (vol. 6, no. 3, Summer 1988), p. 6.

context of the huge budget deficit. The long-term care problem will soon be so critical that Consumers Union supports a comprehensive and universal social insurance program, even though we recognize that such a program will ultimately involve tax increases.

In our January 1989 report, we outlined different long-term care programs for different budget levels. We believe that the cost estimates included in the Pepper Commission recommendations for long-term care (totalling about $43 billion once fully phased in) are extremely cautious. Our recommendations for revenue sources to fund this type of approach include the following:

	Revenue Source:	Expected revenue:
--	Gift and estate tax increases:	$10 billion
--	Uncap the Hospital Insurance portion of the payroll tax:	$8 billion
--	Premiums:	$5 billion
--	Excise tax increases on alcohol and cigarettes:	$3 billion
--	Income tax surcharge or broad based payroll tax	$17 billion

PEPPER COMMISSION RECOMMENDATIONS ON LONG-TERM CARE

While the Pepper Commission has not yet elaborated on proposals for how to finance its long-term care program, the components of its long-term care program are consistent with the parameters that Consumers Union has outlined, and its proposed financing criteria are sound. Some of the most significant

features that we endorse follow. The recommendations:

-- reflect the fact that the long-term care problem is not one affecting the elderly alone; a substantial part of the need for long-term care is among people who are under 65;

-- encourage home and community-based care;

-- provide front-end (first three-month) nursing home coverage, thus benefitting large numbers of people and making a return to the community more possible (financially) for these people;

-- impose a reasonable cost-sharing charge for people over 200% of the poverty level;

-- increase the level of assets protected before an individual becomes eligible for Medicaid benefits for lengthy nursing home stays. The levels selected are reasonable, without being overly generous, and provides people with a large amount of assets with an incentive to buy private insurance to cover the costs of lengthy nursing home stays;

-- make private insurance an appropriate purchase only for people who have substantial assets, and can afford it; they do not make the purchase of insurance appropriate for people of low or moderate incomes or modest assets; and

-- recognize the federal government's responsibility to establish minimum federal standards for private long-term

care insurance (which would wrap-around a federal program).

We commend this Subcommittee for holding today's hearing. The long-term care problem is one that will only grow larger with time. Congress has an opportunity now to alleviate an enormous amount of human suffering by establishing a compassionate program to protect all citizens of our country against costs that can wipe out a family's savings very quickly. We urge you to carefully review the Pepper Commission's long-term care recommendations. We are eager to help you as you continue to consider this important issue. Thank you for providing us the opportunity to present our views.

Mr. WAXMAN. Thank you very much for your testimony.

Let me start off my questioning with Ms. Schaeffer and Ms. Lehnhard.

You both argue that, rather than provide a social insurance approach to long-term care, we should rely on means-tested programs for the poor and on private insurance for everyone else. Yet, on the health care or uninsured side of the Pepper Commission, we struggled to work with the failures of a means-tested public program and the private health insurance market.

Based on this history, why should we expect this approach to work any better for long-term care coverage? In fact, won't it even be worse because we are dealing with a more vulnerable population?

Ms. Schaeffer, do you want to respond to that?

Ms. SCHAEFFER. Mr. Chairman, what we are trying to propose is a workable solution. We don't say that the private long-term care insurance industry can cover the entire group. We do think that there is a role for the public sector to take. What we are trying to do is find a practical solution to the problem where we have costs and benefit tradeoffs. So we are trying to come in with a reasonable approach that would cover the middle and upper income families who can take care of themselves, because we feel that with the limited resources available, the Government should not spend its money in those places.

Mr. WAXMAN. Ms. Lehnhard.

Ms. LEHNHARD. Our rationale is the same. This is a market that we are relatively new in, and it is not an overwhelming market for us. We just recognize the problem of limited Federal dollars and see a way to form a partnership to get those dollars to the low-income who can't afford anything by having those who can afford private coverage take on that financial burden themselves.

Mr. WAXMAN. Throughout the deliberations in the Pepper Commission, we debated whether a public program should cover the "front end" of nursing home coverage or the "back end" of a nursing home stay.

For the record, what is the position of each of your organizations on this question. Why do you think this is the best approach?

Ms. Lehnhard.

Ms. LEHNHARD. We looked at this issue very thoroughly with our member companies that were either marketing benefits at the current time or looking at prospective marketing. They were very concerned that, unless the private insurance were front end, people would have the mistaken perception that they are covered by the Government and don't need private insurance, or that they might not need it if they had come out of the nursing home. We thought there was a way, even if you had a social insurance program, to join together with the Government and use private insurance, much like Medigap. But it would be very important to put the private coverage up front if you wanted people covered.

Mr. WAXMAN. Ms. Schaeffer.

Ms. SCHAEFFER. We don't prefer either the front-end or the back-end approach. What we prefer is a program which targets those who are most in need. When we looked at this, we too figured that we must find a means to target the needy, as you referred to earli-

er. What we did was a study examining the distribution of Federal funds should we provide a program that covered people with asset levels of $8,000, $12,000, $15,000, and so forth, and we found a remarkable thing happened at the $12,000 level. What we found was that, below $12,000 of assets, if you provided protection, as you increased to $12,000, your Government expenditures would increase minimally and the distribution of that increased spending would go to the lower income individuals. But as you passed $12,000, your Government expenditures started increasing and going towards the middle and upper income families, and so we felt that that was the way to go.

Mr. WAXMAN. But you wouldn't do either front-end or back-end coverage?

Ms. SCHAEFFER. No.

Mr. WAXMAN. Ms. Shearer, you argue that we continue to need a major public long-term care program to remedy the deficiencies in the private market. In your opinion, what percentage of the population can we expect to have an adequate private long-term care policy in the future?

Ms. SHEARER. The Brookings Institution did an analysis that estimates that by the year 2018, 25 percent of Americans could afford to buy a long-term care policy. I have to note, though, that there were several assumptions in that figure which, to me, are not ideal. The policies that they were looking at do not have the types of benefits for consumers that we think a minimal private long-term care policy should have, including very comprehensive inflation protection, and nonforfeiture benefits along the lines that some companies are beginning to provide but are not required.

Mr. WAXMAN. So you don't think even the coverage for the 25 percent is going to be fully adequate?

Ms. SHEARER. I think that is optimistic and certainly would be restricted coverage.

Mr. WAXMAN. But if 25 percent has coverage, even if it is not adequate coverage, 75 percent will not. Who are these 75 percent? Who is being left out?

Ms. SHEARER. People who are left out from the private market are certainly people who cannot afford to pay 5 percent of their income for a policy. But it is also the people who will not qualify for a policy because they have an existing health condition; younger people, for example, who are accident victims, and other people who have long-term care needs. People with birth defects, people like that, will not be protected by the private market.

Mr. WAXMAN. Let me just ask one question—my time has expired—of Ms. Schaeffer and Ms. Lehnhard.

Very briefly, would either of you sell a policy, a private policy, to someone who has a birth defect or a middle-aged person who has Alzheimer's? People who have these kinds of serious conditions, are they just going to be out of luck in the private long-term care insurance market?

Ms. LEHNHARD. Mr. Chairman, we have been very clear from day one that we can't sell to those people. Even our companies that do absolutely no medical underwriting in their health insurance—those who don't exclude anyone regardless of their health condition—would have to underwrite long-term care policies. That's be-

cause long-term care is a growing market and the people who need it are the ones who are going to buy it. That would make it totally unaffordable for anyone, unless you were selective in your risk.

Now, as the market grows, it may well reach a point you can liberalize your practices, but in the early stages, it would be totally unaffordable.

Mr. WAXMAN. Ms. Schaeffer.

Ms. SCHAEFFER. I would echo those comments. We don't cover those people, but we never intended to cover them, and that has always been our position.

Mr. WAXMAN. Thank you.

Mr. Scheuer.

Mr. SCHEUER. Mr. Chairman, this was an excellent panel, and I benefited from it very much, and I have no questions. Thank you.

Mr. WAXMAN. Thank you, Mr. Scheuer. I want to thank the three of your for your testimony. We look forward to working with you.

Let me just say to this last panel, we would like to ask you to respond in writing, should there be questions from members of the committee, for the record.

The members of our final panel of witnesses represent some of the providers of long-term care services, those who offer home health care and those who offer institutional or nursing home care. They are here, too, to present their comments on the long-term care recommendations of the Pepper Commission.

Mr. Barry Anderson is president of Alaska Management Technologies, Inc. He is here today representing the National Association for Home Care.

Testifying on behalf of the American Association of Homes for the Aging is the organization's president, Mr. Sheldon Goldberg.

Finally, we will hear from Dr. Paul Willging, who is executive vice president of the American Health Care Association.

We are pleased to welcome the three of you to our hearing today. Your statements will be in the record in full. We would like to ask, however, that you limit your oral presentation to no more than 5 minutes.

Mr. Anderson, why don't we start with you.

STATEMENTS OF BARRY ANDERSON, PRESIDENT, ALASKA MANAGEMENT TECHNOLOGIES, INC., ON BEHALF OF NATIONAL ASSOCIATION FOR HOME CARE; SHELDON GOLDBERG, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING; AND PAUL R. WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. ANDERSON. Thank you.

My name is Barry Anderson; I am president of Alaska Management Technologies, a home care agency serving over 100 communities throughout Alaska. I also serve as a member of the Government Affairs Committee of the National Association for Home Care. On behalf of these organizations, I would like to thank Chairman Waxman and the subcommittee members for holding this very important hearing.

The National Association for Home Care, NAHC, represents approximately 6,000 home health agencies, hospice programs, and homemaker/home health aide organizations. We strongly support the Pepper Commission recommendations on long-term care. NAHC commends the Pepper Commission members, especially Chairman and Senator Rockefeller, for their excellent work. We agree with the Commission's recommendations. Home care must be the basis of any long-term care program. Eligibility must be keyed to disability rather than age. Services should be comprehensive in their scope. The program should be federally funded and structured on a social insurance model, available to all Americans regardless of their ability to pay. And safeguards must exist for cost containment and quality assurance.

Today, I would like to briefly comment on four provisions of the Pepper Commission report—specifically eligibility, copayments, case management, and financing.

First, eligibility. NAHC is concerned that the Commission's recommendation to limit eligibility to persons who need assistance with three activities of daily living may be too restrictive. An individual living alone, unable to carry out even one ADL—for example, eating—can be extremely disabled. NAHC understands that some initial limitations are necessary because of financing. However, we would like to see eligibility broadened to include persons who need assistance with two ADL's in order to better serve the population in need of long-term care.

The second issue is copayments. The Commission recommended a client copayment requirement. NAHC has consistently opposed cost sharing because copayments unfairly increase the burden to beneficiaries, people who already are required to make large out-of-pocket expenditures to finance health care. This requirement may result in some clients going without needed care. With coinsurance, home health agencies or the Government would be put in the position of collecting these payments from clients. From my own experience in Alaska, I can tell you that the administrative cost of this collection activity can be enormous, and it is a cost that would have to be passed on to the program. This would more than offset any moneys generated through the implementation of coinsurance.

The third issue that I would like to address is case management. There is a good deal of ambiguity about the Pepper Commission's recommendations for case management. The confusion results, in part, because of differing interpretations of the term "case management." As a tool for fiscal accountability and integrity, case management is appropriately a function of the Government. Case management, as a means for determining which services best meet the needs of a client, must necessarily be a job for a health care professional.

NAHC believes that the division of responsibilities between payers and home care agency providers should recognize the payer's obligation to protect the program while acknowledging the caregiver's obligation to the client for his or her care. NAHC believes that this balance can be achieved without the imposition of new and administratively costly levels of bureaucracy, levels which ultimately delay the delivery of needed care.

For example, New York State's highly successful Nursing Home Without Walls Program makes use of joint assessment visits by professionals representing provider and payer. Another example of appropriate case management is the use of the interdisciplinary team within the Medicare hospice benefit.

Finally, on the issue of financing, NAHC supports the Pepper Commission's recommendations that the revenue raising mechanism be as progressive and as broad based as possible. There are a variety of revenue enhancement measures that can meet this test. NAHC favors financing a long-term care program through the use of revenues raised by the elimination of the cap on income subject to the 1.45 percent payroll tax. According to a poll conducted by Lou Harris last year, this method of financing is supported by Americans of all ages, professions, and income levels. This included fully 73 percent of those earning more than $50,000 and, therefore, subject to the increased tax.

Additional revenue might be generated by increasing the marginal tax rate on income over $155,000 to 33 percent from the current 28 percent. This tax break for the richest 1 percent of the population amounts to millions of dollars.

Finally, further revenue can come from taxes on alcohol and cigarettes.

I believe that it is important to keep in mind that, not only is the cost of the proposed long-term care program relatively small, but that numerous public opinion polls have repeatedly indicated that the people want long-term care protection and are willing to pay for it.

Long-term care is one of the most devastating problems facing America today. With rapidly changing demographics, this problem is not going to go away. Unless prompt legislative action is taken, it will only get worse. The Pepper Commission recognized this fact and has shown Congress the way to meet this Nation's long-term care needs.

On behalf of the National Association for Home Care and the providers and the beneficiaries we represent, I thank the subcommittee for conducting this very important hearing which starts the process. We look forward to working with you in developing a responsive and responsible national long-term care program.

Thank you.

[Testimony resumes on p. 156.]

[The prepared statement of Mr. Anderson follows:]

Statement of Barry Anderson, President
Alaska Management Technologies, Inc.
Juneau, Alaska

on behalf of the

NATIONAL ASSOCIATION FOR HOME CARE

on

The Pepper Commission Recommendations on
Long-Term Care

before the

Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C.

June 14, 1990

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My name is Barry Anderson. I am President of Alaska Management Technologies, Inc., Juneau, Alaska. I also serve as a member of the National Association for Home Care's (NAHC) Government Affairs Committee.

On behalf of these organizations, I would like to take this opportunity to thank Chairman Waxman and the Health and Environment Subcommittee Members for holding this very important hearing.

The National Association for Home Care, which represents approximately 6,000 home health agencies, homemaker-home health aide organizations and hospices, strongly supports the Pepper Commission's recommendations on long-term care. NAHC is committed

to assuring the availability of humane, cost-effective, high quality home care services to all who require them.

Long-term care is the primary health-related cause of financial ruin among the elderly and the young because neither Medicare nor private insurance provides protection against these costs. More than 80 percent of the cost of catastrophic illness relates to long-term care. Under Medicaid, seniors must "spend down," or exhaust both income and assets, before they are eligible for assistance, which is generally limited to nursing home placement. Currently, more than 9 million Americans of all ages need some kind of long-term care: 60 percent are elderly; 40 percent are under the age of 65. A million Americans a year, two-thirds of them elderly, go bankrupt trying to meet the cost of long-term care left uncovered by insurance. Only the most wealthy of Americans are insulated from the potential financial devastation. The rest can have their lifetime savings wiped out in a matter of months paying for long-term care.

Given current demographic trends of the elderly population, the need for long-term care will increase dramatically. Today, persons 65 years or older represent 12 percent of the population; by 2030, they will represent 21 percent of the population. In addition, persons 85 and older, who are at greatest risk of needing and using long-term care services, are one of the fastest growing age groups in the country.

The Pepper Commission report was historic. Both liberals and conservatives of both parties in an 11-4 vote reached a consensus

on the significance of the long-term care problem and called for swift and comprehensive reform. Further, the Commission set forth a mandate that appropriately targets home care as the best answer to the nation's long-term care needs.

The National Association for Home Care commends the Pepper Commission for setting forth a comprehensive blueprint for a national long-term care program and concurs with the belief that home care should be the core of such a program. Long-term home care improves the quality of life because it is more humane. It reinforces and supplements the care provided by family members and friends and maintains the recipient's dignity and independence, qualities that are all too often lost in even the best institutions. Home care can also be cost effective. New York State's experience with its Nursing Home Without Walls program is that clients who would otherwise need to be placed in a nursing home can be cared for at home for about half the cost. Home care is also cost effective by providing preventive medicine at an early point in an individual's deterioration. Early intervention can often rehabilitate clients to a point where they no longer need even rehabilitative services on a long-term basis.

I would like to briefly review what the National Association for Home Care considers the most crucial of the Pepper Commission's recommendations and comment on four provisions dealing with eligibility requirements, copayments, case management and financing.

Highlights of Pepper Commission Recommendations

The Commission on March 2 voted to recommend a $24 billion social insurance plan to provide long-term home care for severely disabled persons of all ages. NAHC agrees particularly with the Commission's recommendations that:

* home care should be the basis of the long-term care program;

* eligibility be keyed to disability rather than age;

* services should be comprehensive and include skilled nursing, homemaker-home health aide services, physical therapy, occupational therapy, speech therapy, chore services, grocery shopping, transportation services, medication management, training of unpaid or family caregivers, respite care, adult day care, and nursing home care for a limited time with the primary purpose that individuals would return to their homes;

* the long-term care program should federally funded and structured on a social insurance model with benefits available all Americans regardless of their ability to pay;

* financing should be as progressive and broad-based as possible and that it keep pace with benefit growth; and

* safeguards should exist for cost containment and quality assurance.

In general, NAHC supports the Pepper Commission's recommendations that health care is a basic right for all Americans that does not end with advanced age or chronic disability.

Eligibility

The National Association for Home Care is pleased that the Commission recognized the importance of keying eligibility to functional disability and cognitive impairment rather than age. Many families face destitution because of the costs of caring for their chronically ill children and young or middle-aged adults at home. While public and private benefits are sometimes available to pay for the care of these clients in a hospital and nursing home, long periods of institutionalization are destructive to the family and often unnecessary.

NAHC is concerned, however, that the Commission's recommendations to limit eligibility to those individuals who need assistance with three activities of daily living (ADL) (i.e., eating, transferring, toileting, dressing, bathing) may be too restrictive. An individual unable to carry out even one ADL can be extremely disabled and in need of long-term care. For example, an elderly individual, living alone with no family or other caregiver closeby, who needs assistance with only one of these ADLs, such as eating, would benefit greatly from a

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relatively small amount of long-term home care. NAHC understands that some initial limitations are necessary because of financing, but would like, at a minimum, to see eligibility broadened to include individuals who need assistance with two ADLs.

Copayments

The Pepper Commission recommended that client copayment requirements for the long-term home care benefit be set at 20 percent of the costs of care up to a maximum of the national average cost of home and community-based care. NAHC has consistently opposed cost-sharing because copayments unfairly increase the burden on Medicare beneficiaries who already are required to make large out-of-pocket expenditures to finance their health care. Imposing cost-sharing for home health visits would result in some clients going without needed care, thus increasing the number of hospital admissions that could have been prevented by earlier intervention. Thus, far from saving millions of dollars, coinsurance would result in increased costs to Medicare.

Home health agencies and/or the government would be put in the position of collecting coinsurance from the elderly. The administrative costs in doing so would be enormous, and would necessarily be passed along to Medicare. Medicare would have to cover the increased administrative cost of collecting copayments as well as the cost of non-paying beneficiaries. This would more than offset any savings that are anticipated from the implementation of coinsurance.

Case Management

There is a good deal of ambiguity about the Pepper Commission's recommendations for case management. The confusion results in part because "case management" has different meanings for different people. Case management, as a means of maintaining fiscal accountability and integrity, is appropriately a function of the government. Case management, as a means of determining which services best meet the needs of a client, is appropriately a function of medical professionals.

NAHC believes that the division of responsibilities between payors and home care agency providers should recognize the payor's obligation to protect the program against excessive costs while acknowledging the caregiver's responsibility for managing the client's care, and serving as the client's advocate. It is the agency caregivers who are trained for assessments and are in personal contact with the client on a continuing basis. They are the ones ultimately responsible to the client for his or her care.

NAHC believes that a balance can be achieved in which the provider remains responsible for case management and the payor can carry out its utilization management responsibilities without an unnecessary, costly and administratively burdensome duplication of client care planning and review functions. For example, New York State's highly successful Nursing Home Without Walls program has made use of joint assessment visits by professionals representing provider and payor. Another example

is the use of the interdisciplinary team within the Medicare hospice benefit as a form case management. A prior approval for the utilization of services, after an assessment has been done by the home care agency who provides a plan of care, could also serve as an effective safeguard.

Financing

NAHC supports the Pepper Commission's recommendations on financing guidelines; specifically, that the revenue-raising mechanism be as progressive and as broad-based as possible and that it should keep pace with benefit growth.

There are a variety of revenue-enhancement measures that meet this test. NAHC favors financing a long-term care program through the use of revenue raised by elimination of the cap on income subject to the 1.45 percent payroll tax. According to a poll conducted by Lou Harris last year, this method of financing is supported by Americans of all ages, professions and income levels, including fully 73 percent of those earning more than $50,000 and therefore subject to the increased tax.

Additional revenue might be obtained by increasing the marginal tax rate on income over $155,000 to 33 percent from the current 28 percent. As it stands now, those with incomes of less than $155,000 but more than $75,000 pay a marginal tax rate of 33 percent. Those with income over $155,000 pay a marginal tax rate of 33 percent up to $155,000, but 28 percent on income above that level. This tax break for the richest 1 percent of the

population amounts to millions of dollars -- dollars that could go to the neediest Americans.

Further revenue might come from so-called "sin" taxes on alcohol and cigarettes.

It is important to keep in mind that the cost of the proposed long-term home care program is relatively small -- $10.8 billion in the first year as compared to the estimated $180 billion Savings and Loan bailout or the $296 billion defense budget. Numerous public opinion polls have repeatedly indicated the people want long-term care and are willing to pay for it.

Protecting Medicare from Further Cuts

Finally, NAHC would be remiss if we did not take this opportunity to comment that it is illogical for Congress to talk about the expansion of Medicare for purposes of covering long-term care and at the same time to allow deep cuts to be made in the existing Medicare program. Earlier this year more than 200 Members of the House sent a letter to the Honorable Leon Panetta, Chairman of the Budget Committee, underscoring the extent of Medicare cuts over the past several years and recommending that FY91 funding for Medicare be adequate to ensure access to high-quality medical services for the elderly and disabled. We would like to urge the Chairman and the Members of this Subcommittee not only to move forward with legislation implementing the recommendations of the Pepper Commission but also to take a leadership role in preventing further Medicare

cuts whether made administratively or through the back door in the form of Gramm-Rudman-Hollings reductions. In particular, we ask the Subcommittee to examine the arbitrary and unfair manner in which Gramm-Rudman-Hollings cuts have been applied to home care agencies and the other few remaining cost-based programs in Medicare. The effect is Congressionally mandated losses for every home care agency in the country. We hope this Subcommittee will take an active role in preventing further forfeitures of this kind in the future.

Summary

Long-term care is one of the most devastating problems America faces today. With rapidly changing demographics, this problem will only get worse unless prompt action is taken. The Pepper Commission recognized this fact and has shown Congress the way to meet this nation's long-term care needs.

The Pepper Commission appropriately recognized that health care is the right of all Americans, and that this right does not terminate with the advance of age or with chronic disability. The Commission also recognized that in-home care should be at the core of a long-term care program, and set forth guidelines on how to fund this program that are reasonable.

NAHC heartily supports the Pepper Commission's long-term care conclusions and concurs that legislative action reflecting these recommendations must move forward. As the late Congressman Claude Pepper said, "In the name of compassion and in the name of

decency, we cannot continue to permit one million of our citizens to face bankruptcy annually, just because they have the misfortune of contracting a long-term illness. We have the data. We know the problem. We can manage the care of these people and conduct it in a cost-effective manner. For those of us in the Congress not to address this serious need at this important juncture would be a catastrophe."

On behalf of the National Association for Home Care, and the providers and beneficiaries it represents, I thank the Subcommittee for conducting this very important hearing which starts the process.

This concludes my formal statement. I appreciate the opportunity to testify before the distinguished Members of this Subcommittee and look forward to working with you as you continue to work on developing a national long-term home care program.

Mr. WAXMAN. Thank you very much, Mr. Anderson.
Mr. Goldberg.

STATEMENT OF SHELDON GOLDBERG

Mr. GOLDBERG. Thank you very much, Chairman Waxman.

My name is Sheldon Goldberg. I am the president of the American Association of Homes for the Aging; we call it AAHA.

Today in America our 3,500 long-term care facilities and residential programs for the elderly and community services provide care daily to 600,000 Americans. I represent exclusively nonprofit communities, communities that are dedicated to a mission; that mission is serving people. I am proud to share with the committee and you, Mr. Chairman, that they are religiously based, fraternally based, and they have a tradition going back that predates the Constitution of the United States of continuously providing services to people.

What I would like to do in my testimony is just touch on a number of the comments or issues which we raised in our testimony. First of all, let me commend the Pepper Commission for its leadership. It represents a very important first step in terms of focusing on this critically important issue to the American people. It begins the process of building consensus. It starts clarifying public and private roles in terms of how we approach this very important issue facing Americans. It focuses, importantly, on a continuum of services attempting to bring a balance between those in institutions and those which are served in the home and within the community, and it begins to approach realistic solutions in terms of how we phase this in.

I was asked to testify as a representative of providers of care. This view is very important to the equation of how we develop solutions. Perhaps deviating a little bit from our testimony a moment, I have to tell you probably what is the most pressing and important issue affecting providers in their ability to provide care and service to the people.

We asked the members of our organization this past year to tell us what the most important issue was. Interestingly enough, the most important issue is an issue that is not addressed by the Pepper Commission. That issue simply is human resources—that is, people who are willing, able, and trained to serve elderly persons, whether it be in the community or in a home or in a nursing home. That was literally overwhelming of all other issues that they could have identified. It is most important. Anything that is addressing this critical issue has to focus on how we retrain and find people willing to work in long-term care environments both in the community and in the nursing home.

AAHA, the American Association of Homes for the Aging, supports the expanded Governmental role in providing a uniform level of long-term care protection. We seriously are interested in the 3-month nursing home provision as an interesting first step, but we also feel it is very critically important to look at the back end—similar to the legislation you introduced, Mr. Waxman, this past year. We feel it is critically important in terms of how we do that.

But I have to share with you that one of our principal concerns is literally focusing on the adequacy of reimbursement. The Medicaid and the Medicare models, very clearly, as identified by the Pepper Commission, are flawed. Literally, we have experiences from State to State and oftentimes at the Federal level of ratcheting down reimbursement because of economic pressure to numbers that sometimes have no relationship to cost, need, or demands for quality of care. We have seen this happen with moratoriums of State Medicaid payments, and we have also seen it happen in the Medicare program.

We have not rebased the data for calculating rates for over 8 years. It does not recognize DRG's, a sicker and more acutely ill individual. It does not look at minimum wage shifts. It does not look at inflation for service supplies and technology. And obviously, it does not face the really critical issue of retaining staff, and that is having competitive wages to serve people.

A second very critical issue to us, obviously, and supported by issues raised in the Pepper Commission, is the role of a strong long-term care insurance approach as well. We feel that is very critical. We obviously know this is going to be a very expensive proposition. We feel the dollars should go to those who have the least in terms of resources to pay for this. We need to have those who can afford private insurance to purchase it. Those who cannot should have a strong Government program to take care of their long-term care needs. We have to support mechanisms which prefund this liability, prefund this need, when people are in their working years.

We do need a private insurance program. We do need private industry involved in this thing. We support that. These are very important issues raised by the Pepper Commission.

Obviously, we support looking at a number of tax advantages to individuals so that it could help them afford long-term care insurance, especially during their working years but in their retirement years as well. We feel very clearly that we have to look at the needs of insurance companies in this case to provide some incentives in that area.

We believe there is a very balanced approach, and that is what the most important part of the Pepper Commission does. It begins to focus on a number of community services and institutional services as well.

I want to make one comment on the community services because we feel that is extraordinarily important. The Pepper plan calls for three ADL's to qualify people for community services—that is, the same requirements for those entering nursing homes. We would suggest that the eligibility standards for home care should probably be two ADL's. Perhaps that is a little bit more expensive, but that standard would keep people in the most independent state possible. Perhaps we would have to limit the number of units of service in the community services area, but allowing it to go down to a lower level of ADL's to allow people to access the system would be preferable.

A last issue we want to note is that so many people who are elderly are living in low income housing and section 8 qualified housing. It is very, very important that we link services to that population as well.

Mr. Chairman, we want to thank the Pepper Commission for their leadership. They focused on an issue that is critically important. You, Mr. Chairman, we want to thank you for your leadership. You have long been focusing on the issue. What we need to develop is a balanced and a fair system that responds most importantly to the consumer. But we also need a system that recognizes the reality of providers who have to go about providing this service.

Thank you very much.

[Testimony resumes on p. 177.]

[The prepared statement of Mr. Goldberg follows:]

TESTIMONY OF

SHELDON GOLDBERG

AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman, Members of the Committee, I am Sheldon Goldberg, President of the American Association of Homes for the Aging. We are a national nonprofit association representing over 3,500 nonprofit facilities providing health care, housing, continuing care retirement programs, and community services to more than 500,000 older individuals every day. Over seventy percent of AAHA homes are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. With strong community involvement and long-standing community ties, AAHA's members are committed to meeting the physical, social, emotional and spiritual needs of their residents in a manner which enhances residents' sense of self-worth and dignity, and allows them to function at their highest level of independence.

Mr. Chairman, we appreciate the opportunity to testify on behalf of our association concerning the recommendations of the Pepper Commission regarding access to health care and long-term care for all Americans.

We believe the Commission made a valiant first effort at tackling the extremely difficult problems of access and long-term care. The Commission recognized the inequity of people going without needed basic health care or impoverishing themselves to secure long-term care in a country which spends more of its gross national product on health care than any other country in the world. The problems are complex, and agreement has been elusive. Yet the Commission managed to forge consensus on the outlines of a blueprint for the future, and we applaud the Commission's efforts. I should add that my comments here today are based on the Commission's recommendations, many of which remain to be fleshed out in its upcoming report. We look forward to being able to study that report, and possibly make further comments or

recommendations based on it.

While the majority of my remarks will focus on the long-term care recommendations, I must comment briefly on the recommendations regarding access. The Commission has recommended phasing-in universal access to acute health care through employment-based insurance, supplemented by a public program to provide coverage to those not covered through their jobs. Employers of more than 100 workers would be required to provide insurance for their employees or pay into a public program to cover them. Smaller employers would be allowed several years to voluntarily increase coverage of their workers before being included in the full coverage "play or pay" system. While AAHA supports efforts to provide health insurance to employees, we are skeptical about how much of the burden can be shifted to private employers which are already pressured by rising health care costs and staffing costs. By way of example, my own organization has witnessed annual increases of approximately 35 to 40 percent in our own health premiums, and we have a relatively young and healthy employee base. Our members have seen the costs of insurance for their employees increase by as much as 90% in one year. Imposing additional costs to provide greater access could impose a significant financial burden to employers. We understand that the universal access system is to be accompanied by insurance reforms and cost controls, and we look forward to seeing how those specific proposals will help alleviate the pressure on the health care industry as employers.

GENERAL COMMENTS

AAHA commends the Pepper Commission for developing a proposal that represents a responsible first step toward improving our nations's long-term care financing and delivery system. With the modifications proposed by AAHA, we believe that the proposal outlined by the Commission would provide a solid

framework for developing a strong partnership between the public and private sectors. AAHA has long contended that the long-term care financing dilemma cannot be solved by either sector alone. Furthermore, given the growing national deficit and the number of competing interests for federal dollars, we do not believe that the public sector should be solely responsible for shouldering this burden.

AAHA supports the public/private partnership proposed by the Commission which would provide universal coverage for the first three months of nursing home care and additional coverage for those who cannot afford to pay for longer episodes of care. We urge Congress to develop incentives for individuals to purchase private insurance coverage so that, over time, more and more individuals will be covered by private insurance for episodes in excess of three months. The expansion of private sector coverage will protect both consumers and providers against the catastrophic costs of long-term care.

The Pepper Commission recommendations are a good effort to assure the availability of a continuum of care in variety of settings. Care should be available in the most appropriate setting, whether that is in the home, a nursing home, an adult day care center, or other appropriate site or facility. Benefits should be neutral relative to the site of care, that is, they should not encourage institutionalization in order to obtain more adequate coverage. As we discuss the need for services in a continuum of care, it is important that we seek to assure availability of services, regardless of the setting in which the frail elderly individual resides. This may require special efforts to integrate health and supportive services in congregate housing settings, but which could ultimately result in reduced costs for long-term care.

While the Pepper Commission proposed a complete package of home care services, it did not address the special need to link such services to housing for many

frail elderly. This linkage is needed because nearly half of all public housing and Section 8 residents are elderly, and the average age of residents at many elderly housing sites has reached the late seventies and early eighties. While these individuals were nearly all independent when they entered the facilities, now about 25 percent of them require some assistance in daily living to remain independent. This "aging-in-place" phenomenon requires a linkage between housing and supportive services, in order to maintain individuals in their community residences. One example of a successful model is the Congregate Housing Services Program (CHSP), administered by the U.S. Department of Housing and Urban Development. That program provides non-medical, in-home services, such as one meal a day, transportation, personal care, and chore services to residents of several federally-assisted projects in an attempt to prevent unnecessary institutionalization and improve the quality of life for frail residents. Much of the success of the program can be attributed to a service coordinator for each project, who helps assess residents' eligibility and arranges access to services. The program reduced the rate of institutionalization of residents almost in half, and saved from $4,000 to $5,000 per person per year, compared to institutional care. Both the Senate and House Banking Committees last year passed legislation that would expand the congregate housing services program in an effort to deal with the long-term card needs of the elderly in subsidized housing. Clearly the need for supportive services to the frail elderly in congregate housing units is a necessary—and cost effective—measure to be included in a long-term care system.

As we plan to more adequately meet the long-term care needs of our citizens we need to continually examine our assumptions and objectives, and "reality-test" them against current data. I cite as an example our assumption that government should prevent or delay individuals "spending down" almost all of their assets on medical expenses, thereby impoverishing themselves and

becoming eligible for Medicaid. Although this spenddown is usually associated with nursing home costs, high costs of home care or adult day care can also cause impoverishment. Several recent studies have called that assumption into question, and indicate that, while still an issue, spenddown is not as prevalent a problem as was originally perceived.[1] While a number of individuals (about 15 percent) spend down their income and/or assets rapidly (e.g. within 6 months), a surprisingly large proportion of nursing home residents (over 58 percent) never became Medicaid eligible.

The proportion of cases involving Medicaid spenddown was higher among residents with longer stays, but even then, about 37 percent did not have Medicaid as a payment source during that time.

It is interesting to note that although nursing home residents had higher rates of Medicaid spenddown, regardless of income, than individuals receiving community care, greater numbers of those receiving community care spent down than those with nursing home stays. This means that although the public policy debate on spenddown has focused on nursing home care, the risk of spenddown while remaining in the community seems to be a more common problem for many individuals. Research also indicates that acute and chronic out-of-pocket medical care costs, such as for prescription drugs, may be a more direct cause of Medicaid spenddown than, for example, community-based long-term care.

Even if spenddown is not as prevalent as we have thought, that does not mean that the current long-term care system is satisfactory. Disabled elderly individuals with limited assets and income are still vulnerable tc spenddown, primarily due to those out-of-pocket medical costs. Reducing both acute and long-term care expenses of individuals with income and assets marginally above Medicaid eligibility would seem well-suited to most effectively reduce the

risk of spenddown.

This important research challenges our assumptions about the prevalence of Medicaid spenddown due to nursing home institutionalization, and poses the interesting notion that perhaps the benefits which were included in the late Medicare Catastrophic Coverage Act may have been more helpful to those in need of long-term care services than had been previously thought, by preventing or delaying Medicaid spenddown.

AAHA supports the recommendations for a phase-in of the long-term care program. The phase-in will allow the health care system to adjust for gradual changes, and provide the opportunity for mid-course corrections which may be needed. We believe that the seven year phase-in envisioned may be overly-optimistic, however.

COMMENTS ON SPECIFIC COMMISSION RECOMMENDATIONS:

HOME AND COMMUNITY-BASED CARE

The Commission has recommended a national system of social insurance for home and community based care, for severely disabled individuals of all ages, with the federal government financing the home and community based care program. Eligibility would be based on needing hands-on or supervisory assistance with three out of five activities of daily living (ADLs) (i.e. eating, transferring, toileting, dressing bathing) or being severely cognitively impaired. Benefits would include home health care; physical, occupational, speech and other appropriate therapy services; personal care services; homemaker and chore services; grocery shopping and transportation; medication management; adult day health and social day care; respite care; and training

of family members in the delivery of home-based care and support counseling for family caregivers. Individuals would pay 20 percent of the costs up to a maximum of the national average cost of home and community-based care. The federal government would subsidize the coinsurance at least for persons with individuals below 200 percent of the federal poverty level.

The Commission has set forth an ambitious agenda for expanding home care, and we applaud efforts to assure that alternatives to institutional care are available. AAHA members provide many services to help the frail elderly maintain their independence as long as possible. In addition to institutional health and housing services, many of AAHA's members provide a variety of supportive services to the community at large. Our members are committed to a strong continuum of care which can respond to the needs of all who need care.

AAHA supports the Commission recommendation that benefits should cover all individuals who need them but we suggest that long-term care benefits should first cover all elderly individuals. Eligibility for coverage of individuals under 65 should be phased in over a number of years, to manage expenditures and allow orderly implementation. When eligibility is expanded for both children and adults who are chronically ill or disabled, such coverage should be tailored not to displace primary coverage through employers other insurance, or other programs.

We strongly support the Commission's adoption of an eligibility standard based on functional and cognitive impairment. We feel that such a standard is far more equitable to consumers than arbitrary "medical necessity" requirements. We also feel that functional measures are more objective and statistically reliable, and will result in greater consistency in judgements regarding benefit eligibility. The use of objective measures will also provide more effective tools for projecting and controlling program costs.

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Notwithstanding our support of benefit triggers based on disabilities in activities of daily living, we feel that the actual standard proposed by the Commission for home care may be too stringent. Virtually all insurance companies using functional criteria for benefit determinations require a person to be disabled in three or more ADLs to quality for nursing home benefits. Yet the Commission is using the same trigger for qualification for home care benefits. This standard will effectively prevent many individuals from qualifying for federal home care benefits until they are nursing home eligible.

To render a more meaningful home care benefit, AAHA strongly urges the Commission to consider reducing the eligibility standard from three ADL dependencies to two. Since we assume that part of the Commission's intent is to ensure the provision of long-term care services in the most appropriate setting, and to prevent premature institutionalization, we submit that our proposed modification is in keeping with this intent.

AAHA also assumes that the home care eligibility standard of three ADL dependencies is intended to control the costs of a federal home care program. AAHA recommends as an alternative that the Commission limit the total amount of home care services available by capping the maximum benefit at 400 visits per year, instead of providing an unlimited benefit. Such a cap would still provide individuals a substantial benefit while controlling costs. AAHA would contend that individuals requiring care in excess of these limits may, in fact, require institutional support, and that it may be more cost effective to provide care in excess of this limit in an institutional environment. Such environments need not necessarily be nursing homes, but could include assisted living or congregate care facilities that provide supportive services. By increasing flexibility in benefit eligibility standards and capping the maximum benefit, individuals requiring supportive services could gain access

to necessary home care and the federal government could effectively control costs.

We are very pleased to see that the disability standard seems broad enough to provide services to those disabled by dementias, such as Alzheimer's disease. Measures of ADLs alone do not capture the need for guidance and supervision which individuals with dementia require.

AAHA also applauds inclusion in the service package of adult day care and respite care services. Nearly 90 percent of the disabled elderly who remained in their own homes received assistance from relatives and friends, sometimes supplemented by paid providers. American families expend considerable time and effort in taking care of elderly relatives, with one study estimating that families provide more than 27 million unpaid days of informal care each week. Families often incur substantial physical and emotional strains in caring for their elderly relatives, yet federal health policy does little to support those families. A long-term care system must recognize and nurture the important contribution made by family members.

With the modification I discussed, AAHA supports the proposed services package because we think it will provide a range of services which can be tailored to suit individual needs, to keep individuals living in the community as long as possible.

We are unclear as to the calculation of the 20% individual copayment, which is to be based on the "national average cost" of home and community-based care. We hope the commission's report provides clarification of how the national average cost of such a package of services would be calculated. i.e., what data or benchmark would be used, in order to appropriately reflect individual ability to pay, while still being fair to providers and taxpayers?

The recommendation that the federal government should pay the coinsurance for individuals with incomes of less than 200 percent of the poverty level would help to prevent Medicaid spenddown by many of those most at risk.

NURSING HOME PROGRAM

The Pepper Commission has recommended a program of custodial or skilled nursing home care. For the first three months of care, beneficiaries would be required to pay 20 percent of the costs, with federal subsidies for those with incomes under 200 percent of the poverty level. After three months, the government would pay all costs for those with assets below a specified level ($30,000 for an individual and $60,000 for a couple). Individuals in nursing homes could retain $100 per month for personal needs and a spouse remaining in the community could retain all income up to 200 percent of the poverty level. In addition, the Commission would help retain the beneficiary's residence by providing an additional amount (30 percent of monthly income) to be retained as a housing allowance for the first year of nursing home residence for an individual, or for as long as a spouse remains in the community.

Many of these provisions would be of great assistance to those who need nursing home services. The three month up-front coverage would assist 44 percent of those who enter nursing facilities and are discharged within three months. For them, the only cost would be the 20 percent copayment. Because so many individuals do return home within three months, providing a housing allowance for a full year may be overly generous, and may be one area where costs could be trimmed.

Many aspects of the nursing home program remain to be addressed. For example, eligibility is not specified for the nursing home program, as it is for home care. We would encourage the adoption of the standard which is recommended

for home care —— requiring impairment in three or more ADLs, or severe cognitive impairment.

While the Commission has recommended that skilled nursing care and custodial care are included as nursing home benefits, it should be clear that other services, such as physical, occupational, speech and other appropriate therapy services, are also included.

Individuals are to pay 20 percent of the cost of care up to a maximum of the national average cost of nursing home care, but again it is not clear how the national average will be calculated. While AAHA hopes that beneficiary copayments can be modest, we are sensitive to the implications of linking them to costs, and thus to reimbursement. Since in most states the Medicaid programs are currently paying much less than actual costs of caring for beneficiaries, and Medicare cost limits are seven years out of date, AAHA strongly recommends that these costs be updated using figures that are within one year of the date such costs are incurred. Using Medicare costs as a basis would be appropriate because the acuity level of residents has kept increasing since prospective payment for hospitals was instituted in 1983, regardless of the source of payment for care. Furthermore, as of 10/1/90, the distinction between skilled nursing facilities and intermediate care facilities will be eliminated, pursuant to OBRA 1987, and all nursing facilities will be required to meet Medicare standards.

We are pleased to see that the Commission is recommending improving nursing home reimbursement rates and we look forward to learning more about the Commission's plan in its report. Reimbursement under Medicare and Medicaid has meant such problems for providers that almost all must subsidize costs of Medicare and Medicaid losses. Shortfalls of $500,000 per year as a result of under-payments by Medicare and Medicaid are common; some are as high as $2

million. Many of our members are eroding their endowments to pay for operating expenses, in order to continue to subsidize Medicare and Medicaid residents. But the capacity of even not for-profit providers to lose money is limited. State Medicaid programs have been notorious for establishing rates based on fiscal needs rather than on patients' needs or providers' actual costs. As noted earlier, Medicare cost limits are woefully out of date, being currently based on 1982-83 data. The limits do not take into account many increases in provider costs, particularly the increased costs of nurse staffing, which tripled over a three year period for some of our members. The cost limits also have not been adjusted to reflect the more expensive care required by the patient population being discharged from hospitals under the DRG system, to which I alluded earlier. Reimbursement rates which will fairly compensate providers for services to program beneficiaries must be established. We would strongly encourage Congress to include improving nursing home reimbursement in Phase I of its implementation plan. Not only does reimbursement need to be improved now, a more adequate system must be devised in the future to assure that such disparity between costs and payments does not recur.

FINANCING

The Commission has recommended that the federal government be responsible for the home and community-based care program and the three-month front-end nursing home program. The federal and state governments would share the financial responsibility for the longer term nursing home program, but details of that partnership have yet to be worked out.

Although the Commission declined to make specific recommendations of how to finance the long-term care program, it did recommend a progressive tax package, which requires a higher contribution from those with greater

abilities to pay. The Commission also recommended that persons of all ages should pay, since all will be eligible for services. A further recommendation was that program revenues should grow fast enough to keep pace with benefit growth, so that new sources of revenue would not have to be enacted over time.

Public opinion polls have consistently shown that Americans are willing to pay increased taxes for coverage of long-term care services, so perhaps we are more optimistic than the Commission in thinking that financing may not be such a formidable problem. I do not believe that the groundswell of anger over the Medicare Catastrophic Coverage Act which led to its repeal was a refusal by the elderly to pay taxes to fund greater health coverage. Rather I think it was in large part outrage that the social compact of Medicare as being broadly financed was broken, and that the package of services provided did not include those that the elderly perceived they needed the most - such as long-term care. As I noted earlier, public opinion surveys have shown widespread public support for using the Social Security wage tax to fund long-term care, even by those individuals who would be paying the higher tax. Lifting the Social Security Wage cap would increase revenues which are available to fund a long-term care program.

Social Security taxes could be augmented by other taxes, such as the surtax on gifts or inheritance transfers. We suggest consideration of a sliding scale on all such income transfers, with no exclusions. Such a tax would expand the revenue base in a progressive and equitable manner. Use of this tax is particularly appropriate given that a major objective of a long-term care program is asset protection.

Increased taxes on alcohol and tobacco, which have been shown to contribute to health problems, could also be used to fund long-term care needs. We believe this is an appropriate tax for individuals who use such products.

ADMINISTRATION

The Commission has proposed that the federal government contract with states to administer the long-term care plan. The federal government would set standards and guidelines for administration, including standardized assessments to determine eligibility, certification of assessment agencies, guidelines for certifying case managers, determination of case manager budgets and determination of provider payment rates. State governments would enhance current systems for delivering services, certify providers, and establish the review and appeals process.

These proposals for administration could do much to remedy the problems caused by the current dynamics of the federal-state Medicaid "partnership". That partnership is in shambles with the federal government, states, providers and beneficiaries all unhappy with the status quo. Programs vary widely from state to state. Payments to providers are based on state political needs, not providers' costs. Providers have often secured agreements from states on payment changes and reforms, only to have state governments renege on their commitments. Increasingly, providers have had to sue to obtain fair compensation for their services. We will review the final report for details on how the Commission proposes to build a system which will avoid these problems.

PRIVATE SECTOR ROLE

We are pleased to see that the Commission would retain a role for private insurance. We believe that, considering the magnitude of the expenses required to fund long-term care services, a strong partnership between the public and private sectors will be needed. Furthermore, we believe that individuals who can afford to purchase private long-term care insurance should

be encouraged to do so.

We believe that there are appropriate private sector roles for individuals, employers, and private insurers.

To ensure adequate financing in the future, individuals should begin purchasing long-term care coverage during their working years through employer-sponsored health benefit programs. Pre-funding of benefits over the entire labor force would make long-term care insurance affordable to the majority and ensure that not one individual would incur catastrophic expenses.

Employers have a responsibility to help employees obtain access to insurance protection for chronic care services. Employers can begin offering long-term care insurance coverage as part of a menu of employee benefits or through employee-pay-all programs. The Aetna and Travelers insurance companies have developed such policies and report a 15 percent participation rate of employees between the age of 30 and 50. The federal government should offer tax incentives to both individuals and employers to encourage working-age adults to begin prefunding their long-term care needs.

While private individuals and their employers must take responsibility for long-term care protection, private insurance carriers must also provide incentives for purchasing such protection by continuing to improve private insurance policies. Some of the substantial problems with first and second generation policies have been resolved, but many policies still do not provide any or adequate inflation protection, or include services such as adult day care and respite care.

Long-term care insurance coverage is growing, with the number of policies sold tripling in the past two years, and it would seem that the marketplace does

not require tax incentives to offer the types of products currently available. Instead, any federal tax incentives should be tied to products which would meet minimum requirements for range of services and inflation protection.

AAHA supports legislation which would:

1. Provide tax advantages to individuals in the form of tax credits for insurance premiums and tax-free withdrawals of income from IRAs for premium payments for federally-approved policies. Since nearly half of the elderly do not pay income tax at all, an alternative individual incentive could restructure the Medicaid criteria to establish a stop-loss coverage from further asset spend-down for anyone paying for an approved policy for a specified number of years.

2. Provide employers with the same tax advantages for contributing to approved long-term care benefit plans as they currently enjoy for contributing for accident and health insurance;

3. Create an exemption for interest earned on long-term care reserves of approved policies by insurance carriers.

4. Create an exemption for cash surrender values of life insurance policies when paid out in the form of long-term care benefits.

These revisions of the tax code would make long-term care insurance a more attractive and sound opportunity for insurers.

We recognize that Congress is reluctant to enact tax code changes that would erode the tax base, particularly given the current federal deficit. We believe that tax incentives for the purchase of long-term care insurance are justified, since the cost of the incentives could be offset by reductions in

federal spending on long-term care.

We also urge Congress to study several demonstrations which are allowing states to design and purchase long-term care insurance for Medicaid beneficiaries, such as the National Social HMO demonstration and demonstrations funded by the Robert Wood Johnson Foundation in eight states, in order to assess possible expansion of private market coverage.

Expansions of the incentives for private long-term care insurance should include meaningful consumer protection measures. We support efforts to prevent abuses in this burgeoning insurance market and to establish standards for long-term care insurance policies, such as those included in the model Long-Term Care Act, developed by the National Association of Insurance Commissioners.

Mr. Chairman, I appreciate the opportunity to share with you AAHA's views on the Pepper Commission's recommendations. While implementation of a national long-term care system may be many years in the making, it is important that it begin now. AAHA looks forward to working with you and your Committee as you deliberate on measures to develop a more adequate long-term care policy for our country.

1. Spence, Denise A, and Wiener, Joshua M. Medicaid Spend-Down in Nursing Homes: Estimates from the 1985 Nursing Home Survey. The Brookings Institution, February, 1989.

   Burwell, Brian; Adams, E. Kathleen; Meiners, Mark. Spend-Down of Assets Prior to Medicaid Eligibility Among Nursing Home Residents in Michigan. Systemetrics/McGraw-Hill, February, 1989.

   Liu, Korbin; Doty, Pamela; Manton, Kenneth. Medicaid Spenddown in Nursing Homes and the Community. March, 1989.

   Wallack, Stanley S; McGuire, Thomas; Cohen, Marc A; and Kumar, Nanda. An Analysis of Public Proposals for Financing Long-Term Care for the Elderly. LifePlans, February, 1990.

Mr. WAXMAN. Thank you very much, Mr. Goldberg.
Mr. Willging.

STATEMENT OF PAUL R. WILLGING

Mr. WILLGING. Good morning, Mr. Chairman and Mr. Scheuer. We thank you also for the opportunity to testify today with respect to the recommendations from the Pepper Commission.

I am the executive vice president of the American Health Care Association, the Nation's largest long-term care association which represents over 10,000 nursing facilities across the country with over 1 million residents in those facilities.

The Commission certainly deserves high marks for having continued to direct public and social attention to these most critical issues of access and long-term care, particularly with respect to the topic of today's testimony, the need for long-term care services and the financing mechanisms available to fund them.

Clearly, in focusing on that as one of its two areas of primary concern, the Pepper Commission recognized that the catastrophic issue most concerning the elderly today is, indeed, long-term care. The data make that absolutely clear. The catastrophic expenses incurred by the elderly are 81 percent related to long-term care—not hospitals, not physicians, not drugs, not dental services, but long-term care.

The Pepper Commission is also to be commended on recognizing, as is recognized generally throughout the country today, that long-term care is a continuum of services. It is not just nursing homes. It is not just home care. It is not just congregate living. It is that entire continuum of services across the spectrum of the elderly's needs.

I think also we particularly would emphasize how important it was that the Pepper Commission recognized that there is indeed a nexus between resources and quality. We have too often in this town denied the reality of that basic fact. It is true that resources are not a sufficient condition for high quality care in America's nursing homes, but it is clearly true that they are a necessary condition. For having recognized that basic reality, we would commend the Commission.

I think our biggest concern, however, Mr. Chairman, relates to the questions you directed to the previous panel; that is, the issue of the nature of the public/private partnership in terms of front-end funding or back-end funding. There we have some serious questions. We think front-end funding flies in the face of two or three basic realities.

The first is that it seems to deny what is, indeed, the catastrophic risk faced by the elderly. It is not that first 3 months in a nursing home that creates the problem. It is clearly the extended stay, and we have seen that more and more in some of the data that has been recently published. I refer primarily to the Urban Institute's study conducted by Josh Weiner which shows that, in fact, the spend-down issue is not as serious as had once been thought. In fact, of private pay patients entering a nursing home, only 10 percent spend down over the course of their stay. We further find that

that percentage is most pronounced when the stay extends past 2 years.

So, again, to cover the front end of a nursing home stay which is not catastrophic seems to deny the reality of the spend-down process itself. Further, that leads to the issue of resource expenditures on the part of the funding mechanism—in this case, the Federal Government. A $44 billion program is, indeed, inevitable if we take on what is the burden that most of the elderly could carry on their own rather than taking on the burden that most of the elderly cannot deal with—that is, the catastrophic stay.

A program with that level of expenditure gives us pause to reflect on what we have today when we have, perhaps, overpromised and have not been able to follow up with funding.

You are to be commended, Mr. Chairman, for having spearheaded the enactment in 1987 of the Nursing Home Reform Act within the Omnibus Budget Reconciliation Act. For the first time in many years, it looked as though we would finally be able to provide to Americans in need the kind of quality long-term care services in institutions that they deserve.

You made it clear in that legislation, Mr. Chairman, that States in their Medicaid rates were going to have to fund this new level of quality. Unfortunately, Mr. Chairman, almost 3 months after the States were to have submitted their plans for that funding, not one has been found acceptable by the Health Care Financing Administration. In your own State, Mr. Chairman, it has been publicly stated that not one dollar of additional funds will be made available for OBRA.

My concern, Mr. Chairman, is, what happens when we promise too much? What happens when we launch possibly new programs where we have not yet adequately funded existing programs? I think the Pepper Commission, again, is to be commended for having focused on this issue, but I would strongly urge this committee and the Congress to look at the degree to which we have to do what it is we promised to do in previous programs. We have not yet done that. We would urge we make sure that we do well what we have set out to do before we set out to do major new initiatives.

Thank you very much.

[Testimony resumes on p. 189.]

[The prepared statement of Mr. Willging follows:]

STATEMENT OF AMERICAN HEALTH CARE ASSOCIATION

Thank you Mr. Chairman and members of the Committee. We appreciate the opportunity to testify here today regarding the Pepper Commission recommendations on long term care. My name is Dr. Paul Willging, Executive Vice-President of the American Health Care Association. AHCA is a non-profit federation of fifty one state affiliates which represents approximately 10,000 individual nursing and allied health care facilities who provide care to more than 1,000,000 Americans. We would like to commend the dedicated efforts of the members of the Pepper Commission for addressing the very difficult issues surrounding the provision of quality long term care services to our nation's elderly and disabled population.

Overall, AHCA appreciates the emphasis throughout the Pepper Commission recommendations to provide the highest possible quality of care to our nation's citizens who are in need of long term care services. We also recognize and support the need for an array of quality care providers within the health care continuum, ranging from nursing facilities to settings within the individuals' own homes. The Commission has laid the foundation to address the problems of funding long term care services for persons

in need. AHCA would like to offer the following perspectives about the current status in achieving quality of care for nursing facilities, as well as offer constructive modifications that we believe will provide the best possible solutions for the future.

Quality of Care and Reimbursement Levels: Current Status

We applaud the recommendations of the Pepper Commission designed to further enhance the quality of care within nursing homes. Specifically, the Pepper Commission has recommended that $6 billion be provided during the implementation of the project to increase nursing home rates to improve the quality of care. AHCA appreciates the recognition of the Pepper Commission that quality care and resource allocation are inseparable components. This is especially significant in light of the current situation of increasing the expectation of performance in nursing facilities.

Today, the nursing home industry is working with patients, families, consumer groups, and government officials to implement the prescriptions of the 1987 OBRA Nursing Home Reforms. AHCA strongly supports the goals of this important legislation to provide the highest level of individualized services that our patients may require. However, given that a majority of patients in nursing homes depend on government funding to pay for their care, quality of patient care is inextricably linked to how much the government is willing to pay to achieve it. Under the Med

icaid Program, government payments for patient care are shaped by strong economic incentives devised by the states to limit state spending. Providers who have a need for more medical services than the "average patient" often receive lower payments than their costs. Simply put, rate systems penalize providers who exceed the industry's averages.

In addition, incentives to improve the physical environment of a facility are also hampered due to delays of two years or more between the time a cost is incurred and the time it is recognized by the government for reimbursement. These strategies have combined to restrict the payments to nursing facilities below levels necessary to sustain their future financial viability.

It must be emphasized that it is these payment levels that also determine the number of doctors, nurses, therapists, and social workers within a facility that define the quality of care within a nursing home.

Congress has recognized that to achieve the higher quality of care required under OBRA that new costs will be incurred for better training of nurses, more detailed patient assessments, and more services to meet individual needs. Unfortunately, states that must fund these programs often face the same budget limitations currently found at the federal level. The result is that new programs such as OBRA, are at worst, simply not funded, or often, not funded at an adequate level. AHCA is currently re

viewing state plans to fund OBRA, and we are frighteningly aware that some states are publicly admitting that they cannot afford to fund the OBRA requirements and do not intend to do so. The unfortunate result is that nursing homes are now being held accountable in government surveys to the level of care mandated by the new federal law, while the necessary government funding to implement the law is not measuring up to the same high ideals. We are also concerned that HCFA will then publish the results of these surveys as its guide to consumers, citing the failure of nursing facilities, when some states have refused to implement the reforms.

The result is that nursing homes fall in the middle of two major conflicting political forces, both with very strong public and political support. We face new pressures and ideals to achieve higher levels of quality of care that has unquestioned universal support - by AHCA, by our providers, patients, families, advocates, and government leaders. This must be reconciled with funding that is also under greater pressure than ever before of no new taxes, no new funding, budget reductions, and paralyzing budget deficits throughout the state and federal governments. The end result places nursing homes in the middle of a difficult and unresolved public dilemma.

The Future: AHCA Recommendations

We are not satisfied with the quality expectation/resource allocation ratio under federal standards and funding programs. The key becomes what solutions can be found to improve this current dilemma between demands for better quality of care and the adequate funding to achieve it. Again, we appreciate the Pepper Commission's willingness to frame solutions that address these difficult issues for the future.

AHCA supports this effort and offers the following suggestions as principles for developing a comprehensive approach to the long term care problems facing us.

First, patients should be placed in appropriate health care environment based on their individual needs. As a fundamental recommendation for a quality health care system, AHCA supports the availability of an array of health care providers that begins with the family as a primary caregiver. The continuum of health care providers must include a range of settings options that can best meet the medical needs of patients needing long term care services. Further, the full continuum must be managed to promote quality of care through fair payment rates, quality standards, and an effective system to ensure that patients are placed within the continuum based on their individual needs.

We would suggest that a comprehensive case management system, with adequate qualifications, training, and guidelines for case managers, should be an integral part of such a system to protect appropriate placement for patients. While we recognize and support an array of health care providers, we do not support placement or diversion of patients into or from health care environments based on incentives for budget reductions. As new programs for alternative health care providers are developed, we must be cautious to ensure that incentives are not created to simply move patients in need of medical care based on economic incentives to reduce government expenditures. A fair and independent case management system would address these concerns.

Second, AHCA believes that government resources for assisting individuals pay for the costs of long term care should be targeted to those in legitimate need. For example, the social insurance program recommended by the Pepper Commission that includes 90 days of automatic coverage for a stay in a nursing home would provide the same benefit to all individuals, regardless of their need for government assistance. As we are all affected by the virtual freeze caused by the budget deficit, we have been convincingly persuaded that government resources are indeed scarce, and should be directed to the areas of greatest need. However, under this proposed benefit program, individuals with unlimited wealth and assets would receive government payments for the temporary stay in a nursing home.

We believe that this example also illustrates another fundamental recommendation to improve the efficiency of government expenditures for long term care - that government assistance for long term care should be available only after a period of personal responsibility. Persons without adequate resources would be immediately eligible for government assistance. It is not the first few months of a stay in a nursing home that presents the most serious financial burden to patients. It is the prospect for long term stays that can completely deplete individual's and families savings and assets before they become eligible for government assistance. AHCA would therefore recommend that government assistance be provided only after a period of personal responsibility, with government preserving its role as the payor of last resort.

This funding approach, which is in contrast to proposals for "front end coverage", would be consistent with your legislation (S. 4763) proposed last year for funding long term care, which recognizes a need for some time period of personal responsibility prior to eligibility for government assistance.

A recent Brookings Institution report on the Medicaid "spend down" in nursing homes has documented that over 90% of private pay individuals admitted to a nursing home would not need government assistance during the first two years of their stay. Further, the percentage of these individuals needing government assistance jumps to over 25% if their stay exceeds the two year period. This data provides evidence that most persons do not need

government assistance for short stays in a nursing home, but that a very high percentage of persons will eventually need funding assistance after an extended period. We believe this is the area where government resources can be most efficiently allocated to meet the needs of Americans for long term care services.

Next, AHCA supports the continued fostering and support of a public/private partnership to provide a comprehensive system to support our citizens' needs for long term care. Private insurance for long term care must play a major role to contribute a piece of the funding puzzle to reduce the need for further government expenditures. In addition, allowing for a period of personal responsibility prior to eligibility for government assistance would create a finite time period that should encourage the development of private long term care insurance to meet this need. Given that the time period would be limited, insurance companies would not face unknown and unlimited benefits which increase the costs for insurance premiums.

The Pepper Commission has made reference to a growing role for long term insurance through "clarification of the tax code." AHCA would favor more specific proposals involving tax incentives for expenditures for long term care insurance. For example, the Robert Wood Johnson Foundation has developed programs with several states to foster the development of quality long term care insurance programs through economic incentives. We also

recognize the need proceed cautiously as these new alternatives become available, with appropriate quality controls, to ensure the effectiveness of long term care insurance programs.

In addition, incentives should be retained under government funding programs to encourage private sector participation in the nursing home industry. During a time when our elderly population is rapidly increasing and many studies have documented the need for greater long term care services, we believe that proper incentives should be retained to attract the private capital necessary to meet these new demands.

As a fundamental component of any proposed reimbursement system, AHCA would recommend a prospective payment approach that provides a fair reimbursement to providers. The basic components of such a reimbursement system would include payment for the full costs of patient care based on acuity levels, incentives for efficiency for reimbursement of administrative costs, and a fair return on capital costs. Several states currently have developed "case mix" reimbursement models based on these principles, which has improved the targeting of payment rates to those with the greatest needs.

Within the consideration of government funding and rate structures, AHCA would oppose the government establishing rates for all patients and payors, regardless of whether the patient was eligible for government assistance. Some of the finest nursing

facilities with the highest quality of care have a high percentage of private pay patients that allows the facility to provide additional benefits, including private rooms, higher quality physical environments, greater variety and specialty in providing an array of needed services to their patients. Establishing a maximum ceiling for all payors would eliminate this opportunity, as all facilities would be set at a level of the lowest common denominator that the government could afford to pay. Quality of care would be reduced for many patients and facilities if this recommendation were implemented.

We appreciate the opportunity to testify here today, and we look forward to continuing to work with you to develop solutions to provide adequate funding to meet our nation's needs for long term care services. I will be happy to answer any questions you may have.

Mr. WAXMAN. Thank you for your testimony.

The private insurers whom we have just heard from argue that Government financing for long-term care services should be severely limited, leaving a larger role for their companies. We all agree that some mix between the private and public sectors in providing long-term coverage is appropriate. I would like to know from each of you what you think is the proper mix.

Mr. Anderson.

Mr. ANDERSON. Mr. Chairman, in Alaska we have virtually no private insurance market to speak of in the area of long-term care, so I am not really in a position to respond. I can go back to the National Association for Home Care and get you some response to that.

Mr. WAXMAN. Okay. We will be pleased to receive it for the record.

[The following letter was received:]

NATIONAL ASSOCIATION FOR HOME CARE,
Washington, DC, July 25, 1990.

Hon. HENRY WAXMAN,
Chairman, Subcommittee on Health and the Environment,
Committee on Energy and Commerce, Washington, DC.

DEAR CONGRESSMAN WAXMAN: During the subcommittee hearing conducted on June 14, 1990, Barry Anderson, witness for the National Association for Home Care, was requested to provide further information for the record. In response to your question, Mr. Chairman, the following is being submitted:

The Federal Government must take the lead in providing adequate coverage for long-term care needs. The private health insurance industry has made efforts to cover long-term care, but the policies which currently exist are few in number and are riddled with exclusions and limitations. To the extent that policies exist, they typically pay indemnity and not service benefits, and their coverage is limited to nursing home care or includes minimal home care provisions. Most long-term care policies have serious limitations: Failure to index benefits for inflation; limitations on renewability; restrictive prior hospitalization requirements; exclusions for coverage of mental and nervous disorders; restrictive focus on skilled nursing care services; and prohibitively expensive premiums.

Given the cost of a comprehensive long-term care policy and its associated risks, it is not likely that the insurance industry will be developing adequate policies within the foreseeable future. The problem of long-term care requires the national approach to provide a basic range of services, which can be supplemented by the private sector.

The Brookings Institute, in a 1988 study, concluded that the most straightforward approach in Federal financing of long-term care is adding to Medicare. The American people also favor a Federal program to provide long-term care. A national poll taken in 1988 by Louis Harris and Associates shows that 8 out of 10 Americans favor strong Federal involvement.

Mr. Chairman, we appreciate the opportunity to expand our testimony. Please feel free to contact me should you need any further information.

With warm regards,
Sincerely,

VAL J. HALAMANDARIS, *President.*

Mr. WAXMAN. Mr. Goldberg.

Mr. GOLDBERG. Our concern is for the critical precious resources, dollar resources, to fund this thing. To the extent that individuals have the ability to pay for this and to the extent that they have the capacity to buy these long-term care policies, we think there ought to be incentives and urge them to buy those policies.

We are very much concerned about the catastrophic focus of long-term care services, whether it be home care or whether it be

nursing home care. That approach comes very close to a piece of legislation you introduced last session on back-end protection.

We think there need to be incentives for people to buy long-term care insurance, but we cannot forget for a moment that the Federal Government and State governments, to a lesser extent, are going to have a very critical role in paying for this. I happen to feel they will have a dominant role.

Mr. WAXMAN. Mr. Willging.

Mr. WILLGING. I share much of Mr. Goldberg's views, Mr. Chairman. I think there is a role for the Federal Government, as I suggested in my oral testimony. I think that role kicks in most appropriately where the catastrophe kicks in—that is, at the back end, be it over 2 years, 3 years, or be it over a set dollar amount.

I believe in that interim period, there is clearly a critical role for long-term care insurance in the private sector, and I am quite pleased with the progress that has been made in the insurance industry with respect to long-term care. We now have 118 companies selling those policies. We now have over 1.5 million policies in force. Ten years ago, we had about 40,000 policies in force. I think it shows that progress is possible. There is much progress yet to be made. But it is that front-end coverage, I think, which provides the best opportunity for the private sector largely through insurance companies.

Mr. WAXMAN. If we are trying to protect people from spending down, from being impoverished, we need to set some limits. The Pepper Commission recommended that we protect $60,000 of assets. Is that the right amount? Too little? Or too much?

Mr. Goldberg.

Mr. GOLDBERG. I would respond, I don't know, and I don't know if anyone knows for sure what that right amount is. It is an important step to recognize that we don't want to destroy people's assets, their life savings, especially for the spouse who may remain back in the home. So I think it is an important first step. I don't think anyone has the magic number, but it is a very realistic and reasonable number.

Mr. WAXMAN. The insurance representatives testified that they thought $12,000 was a good cutoff point.

Mr. GOLDBERG. I don't know if I would agree with that.

Mr. ANDERSON. Mr. Chairman.

Mr. WAXMAN. Mr. Anderson, go ahead.

Mr. ANDERSON. Ironically, last week my mother reached the point at which all of her assets are depleted. She is now receiving long-term care in a wonderful institution in New York.

You reach a point—whether it is $60,000 or something less—where you have got a human dignity issue. Sixty thousand dollars may be a tad high, but I personally think $12,000 is way, way low.

Mr. WAXMAN. Mr. Willging.

Mr. WILLGING. The answer is a simple one, Mr. Chairman. If I have less than $60,000 in assets, I think it is a wonderful level, and if I have more, I think it is a terrible level.

I think I would probably suggest, though, as Mr. Anderson had, that the whole concept of spend-down, the whole concept of asset protection, does suggest something about the dignity of programs which do, in effect, at whatever level, require people to divest

themselves of resources. What we have found in the Medicaid program is that it requires as much divesting oneself of dignity as it is of resources.

Mr. WAXMAN. But your proposal is to cover the back end of nursing home care. What if someone can't pay for that front end of nursing home care? How would you want that handled for that individual?

Mr. WILLGING. I would certainly, for those who, in fact, cannot afford the insurance, do not have the assets at all, I would not propose eliminating the Medicaid program. It should be designed so as to fit into that front end.

I would, however, suggest that the most appropriate way to do that is for the Medicaid program not, in a sense, to continue as a vendor payment program, as it is today, but to buy the insurance on behalf of those who cannot afford it themselves.

Mr. WAXMAN. However it is done, at what level would you decide the Government should step in either to buy the insurance or pay as a vendor for the service—$12,000? $60,000?

Mr. WILLGING. I would probably have it on a sliding scale, Mr. Chairman. I would not, in effect, cut it all off at any certain level. I would say at a certain level of poverty, within whatever range of the poverty level, in asset and in income, the amount of money that the Federal Government would pay would be altered.

Mr. WAXMAN. You might want to elaborate on that for the record, to tell us where you would come down.

Mr. Goldberg.

Mr. GOLDBERG. Mr. Chairman, I think the key issue is the spouse that remains at home. I think that is what we most importantly have to pay attention to and have adequate resources for. That person should be able to continue living in the home and meet his or her needs. That is really the central issue.

Mr. WAXMAN. One of the concerns that has been raised about the Commission's proposal regarding home care services is that the eligibility criteria contained in the plan may not always be appropriate for the nonelderly, particularly children.

Mr. Anderson, your organization provides home care services to Americans of all ages. Do you think the eligibility standards in the Pepper Commission report will work for the nonelderly? If not, what should we use?

Mr. ANDERSON. I think the use of ADL's is the best approximate measure, Mr. Chairman, that we have available today. I believe that the appropriate population, the population we wish to address through long-term care, could be most adequately served through an eligibility standard of two ADL's, a deficiency in two ADL's as opposed to the three that the Pepper Commission report includes.

Mr. WAXMAN. Mr. Willging, your testimony cites a study showing that over 90 percent of private pay individuals entering a nursing home will not need Government assistance during their first 2 years. Is it your position that Government assistance for people who stay in a nursing home for less than 2 years should not be provided at all?

Mr. WILLGING. With the exception of those who, in fact, cannot afford the alternative mechanisms, as I indicated, no, I don't think the Governmental role is appropriate until, as I indicated, the ca-

tastrophe has begun. And the catastrophe begins, according to that study, at around 2 years for most Americans. Spend-down is not as serious a problem as we thought it was previously.

Mr. WAXMAN. Does that mean you are opposed to the Pepper Commission's 3 month front-end benefit?

Mr. WILLGING. Yes, sir.

Mr. WAXMAN. If you are opposed to that 3 month front-end coverage, why was it that the American Health Care Association worked so actively to keep Congress from repealing the catastrophic act's skilled nursing facility benefit which provided similar coverage on a social insurance basis?

Mr. WILLGING. Because that was the option we had at that time in terms of a Federal funding program for the extended care patient. That benefit, the SNF benefit, was enacted years ago with the Medicare program and was designed, in effect, to provide a more cost effective and more efficient approach to dealing with the activities, medical activities, that commenced in the hospital. We felt that that was, in fact, the one aspect of the catastrophic law which made some sense and fought, as you say, very hard to maintain that.

Mr. WAXMAN. Would you then say that if we are talking about admission into a nursing home from a hospital you would support front-end coverage? I am trying to understand why, in one case, you think front-end coverage ought to be covered under Medicare and now you are arguing that you don't think it is needed.

Mr. WILLGING. Well, because I think, as I suggested, we were looking at what we had available at the time as opposed to what we are talking about now. Today, we are talking about a major, almost revolutionary change in terms of long-term care funding.

If we, as is suggested in the results of the Pepper Commission, are talking about revising our entire approach to long-term care financing, then we needn't worry about whether this aspect of an existing program should stay or go. I think in terms of what we had available to us at the time of the catastrophic law—and we were at the time talking about a major change in long-term care financing—that was, in fact, the best opportunity as far as the expenditure of Federal funds within the catastrophic bill. But here we are talking about a major revolutionary change where we can, in fact, make choices based on what is best across the board, not in terms of the existing Medicare program.

Mr. WAXMAN. Mr. Scheuer.

Mr. SCHEUER. Thank you, Mr. Chairman. I have no questions.

Mr. WAXMAN. Okay.

I think you have been very helpful to us. I appreciate the testimony you have given, and I would like to have you available to respond in writing to questions that members of the committee may wish to submit to you for response.

Thank you very much.

That concludes our hearing for today, I thank all the participants. We stand adjourned.

[Whereupon, at 12:06 p.m., the hearing was adjourned.]

[The following statement was submitted:]

PREPARED STATEMENT OF HON. DAVID DREIER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you Mr. Chairman and members of the committee for the opportunity to submit my comments regarding the Pepper Commission recommendations on long-term care. I appreciate the effort the members of the Commission and this committee are giving to the difficult issue of providing long-term care services to our Nation's elderly.

Census Bureau statistics show that those over age 65 will account for more than 21 percent of the U.S. population by the year 2030. At the same time, our nursing home costs are expected to reach $55 billion this year, from $4.7 billion in 1970. Obviously, most individuals cannot cover a nursing home bill averaging $23,000 a year. And most do not have insurance to cover such care.

Yes, the Federal Government should take a leadership position on long-term care. But this leadership should not take the form of a new $42.8 billion government program.

Obviously, providing long-term care benefits under the Medicare program would require a sharp increase in the Medicare payroll tax or increased taxes on the elderly. Public outrage over the Medicare Catastrophic Protection Act made it clear that no one wants these tax increases. And, every time we pass a health care program, the actual cost is much greater than projected.

A massive federally sponsored long-term care program is not necessary. Instead, Congress should encourage a market solution to this serious and growing problem. Good long-term care insurance policies offering nursing home and home health services are now available in all 50 States. In recent years, employer-sponsored group products have entered the market. Over time, long-term care insurance products are sure to grow in number, and in the services offered.

Rather than duplicating, and consequently wiping out this market, Congress should offer incentives for the industry to create efficient long-term care insurance products.

I would like to bring to your attention legislation I have introduced to do this. H.R. 3440 is a comprehensive bill to facilitate private sector development of long-term health care insurance. The development of such a market is the key to ensuring the availability and affordability of insurance products to protect all Americans against catastrophic costs associated with extended hospital stays and custodial care.

Specifically, H.R. 3440 allows for tax-exempt withdrawals from IRAs for the purpose of purchasing long-term care insurance. It would allow a company to offer a higher deductible health insurance package and contribute the premium savings to an employee IRA, whereby the funds could be withdrawn tax-free to purchase catastrophic or long-term health care insurance.

In addition, it would eliminate the Certificate of Public Need [COPN] program, which many States use to limit competition in the nursing home industry and keep nursing home costs artificially high. It would also allow for the conversion of life insurance policies to long-term care insurance, and provide preferential tax treatment of long-term care insurance similar to the tax treatment as life insurance reserves.

Mr. Chairman, a massive federally sponsored long-term care program is doomed to failure, and, as was the case with the catastrophic care law, Congress should not mislead the elderly by exaggerating the limits of a Federal response. Instead, Congress should encourage a market solution to this serious and growing problem.

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